NEBRASKA SYSTEM OF CARE EXPANSION INITIATIVE: READINESS ASSESSMENT

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EXECUTIVE SUMMARY

The University of Nebraska Public Policy Center conducted a self-assessment of readiness for expanding systems of care in Nebraska. We used two methods: 1) a survey of 783 families, youth, service providers and other stakeholders, and 2) discussion forums in all six behavioral health regions involving 319 participants. Key findings include the following:

- Overall, participants gave the current system of care average grade of between C- and C. Family members and individuals involved in Developmental Disabilities, Healthcare, and Substance Abuse gave lower system ratings.
- Nearly all system components were found lacking. At the community level, the most lacking components are 1) a clear and feasible plan for sustaining fiscal support, 2) a local social marketing plan, and 3) youth as influential partners. At the state level, the most lacking components are 1) an effective approach to coordinate funding, a clear and feasible plan to sustain fiscal support, and an appropriate array of services.
- Priority needs at the community level include developing accessible services, a broad array of effective services, and a focus on prevention. At the state level, the priority needs were developing accessible services, maximizing federal funding, and developing a broad array of effective services.
- Participants indicated the state should model the system of care approach by provide the framework, data and resources for local implementation of systems of care.
- Participants recommended developing a common curriculum for trauma informed care training, systematically implement trauma informed care across systems and monitor fidelity to evidence based trauma informed care practices.
- Participants recommended developing a broader array of services including informal support systems, transportation, school-based services, and crisis intervention.
- Participants suggested increasing opportunities for system level involvement for youth and families and equipping them with the skills to participate effectively in policy development.
- Participants recommended developing a shared understanding of cultural and linguistic competency, attending to the cultures of different service delivery systems, enhancing recruitment and retention of diverse professional staff and interpreters, and ensuring diverse representation in all aspects of system planning and evaluation.
- Participants proposed increasing funding for children's behavioral health services, sustaining funding over the long term, enhancing funding for mental health services in schools, ensuring funding can be used flexibly for formal services and informal supports, and developing adequate reimbursement rates to support evidence based practices.
- Participants recommended better use of other system professionals, methods to improve recruitment and retention of providers, and training on topics such as trauma-informed care, evidence-based practices, social and emotional development.
- Social marketing and strategic communications were not seen as high-need areas.

- Participants proposed increasing access to wraparound and developing a consistent model and common training approach across systems.
- Participants suggested greater emphasis on prevention and early intervention including locating services in schools and medical settings.

INTRODUCTION

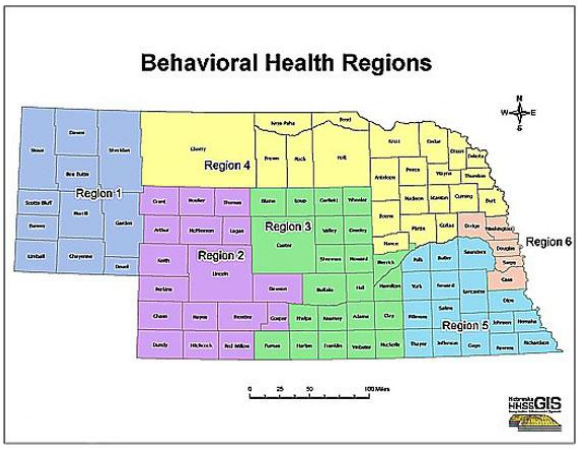
The Nebraska Department of Health and Human Services (DHHS) contracted with the University of Nebraska Public Policy Center to conduct a self-assessment of readiness for expanding systems of care in Nebraska. The self-assessment is part of the Nebraska System of Care Expansion Initiative, an effort funded by the Substance Abuse and Mental Health Services Administration designed to create a statewide comprehensive strategic plan for prevention-oriented, culturally and linguistically appropriate, and family-driven, youth-guided SOC for children/youth with Serious Emotional Disturbances and their families.

METHODS

Two methods were used to gather the information for the readiness assessment: 1) a survey administered on-line and on paper and 2) discussion forums conducted in each of the six behavioral health regions in Nebraska. The survey was distributed by system partners over a period of three weeks. The sample was one of convenience and was generally composed of people in Nebraska with involvement in or concerns about the child and youth serving systems. The survey and discussion questions centered on the 10 core strategies adopted by the Nebraska system of care Project Management Team in this planning initiative:

1. Policy/ Administration
2. Trauma-Informed Care
3. Services and Supports
4. Family and Youth Partnerships
5. Culturally and Linguistically Appropriate Services
6. Finance
7. Workforce Development
8. Social Marketing and Communication
9. High-Fidelity Wraparound
10. Prevention

Survey and discussion questions were developed in collaboration with the Project Management Team. The discussion forums were organized with the help of behavioral health regions, DHHS service areas and Nebraska Federation of Families local affiliates. The discussion forums were separated by constituency groups: 1) youth, 2) family members, and 3) stakeholders including mental health and substance abuse service providers, children and family service workers,



juvenile justice professionals, educators, health workers, early childhood professionals, and vocational rehabilitation. Forums were held on the following dates:

- Region 1 November 15
- Region 2 November 14
- Region 3 November 18
- Region 4 November 12
- Region 5 November 20
- Region 6 November 22

A total of 42 discussion forums were conducted that included 319 participants – 27 youth, 82 family members and 210 stakeholders. Table 1 shows the number of participants by region. There were 783 survey participants. Table 2 shows survey participants by region and participant group. Nine youth, 108 family members, and 669 stakeholders participated in the survey. Nearly 92% of respondents were white and non-Hispanic/Latino.

Table 1: Discussion group participants

Region	Family	Youth	Service System	Total Discussants
1	4	2	56	62
2	18	5	23	46
3	18	2	33	53
4	6	0	8	14
5	25	16	38	79
6	12	5	48	65
Total #	83	30	206	319

Table 2: Survey participants by region and group

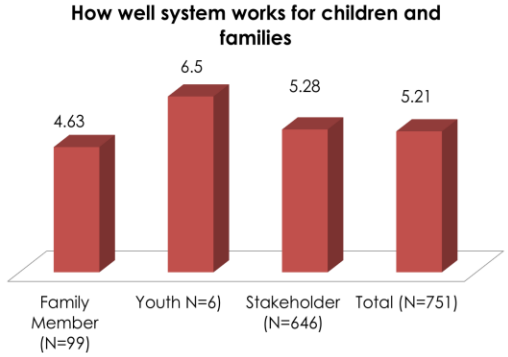
Regions	Family	Youth	Service System	Respondents
Region 1	11.3%	1.9%	86.8%	53
Region 2	16.1%	0.0%	83.9%	31
Region 3	9.1%	2.4%	88.4%	164
Region 4	13.3%	1.2%	85.5%	83
Region 5	13.8%	0.5%	85.7%	210
Region 6	18.6%	0.5%	80.9%	188
Statewide	9.3%	1.9%	88.9%	54
TOTAL	13.6%	1.1%	85.2%	783

RESULTS

GENERAL RATINGS

Overall, survey participants gave the Nebraska system of care a grade of C- to C in rating how well it works for children and families. This indicates generally less than positive views and room for improvement. The grade varied by participant group, indicating the system may benefit some groups more than others. For example, family members rated the system lower than other groups (see Figure 1).

Figure 1: System rating by participant group



1 = F, 2 = D-, 3 = D, 4 = D+, 5 = C-, 6 = C, 7 = C+, 8 = B-, 9 = B, 10=B+, 11=A-, 12=A, 13=A+

Survey participants were asked to the degree to which they agreed that system of care components exist in their communities and at the state level. Generally, survey participants indicated most system of care components are lacking in their communities and at the state level (see Tables 4.1 and 4.2 in Appendix 4 for the ratings of all system of care components). Only three components averaged positive ratings at the community level and no component averaged positive ratings at the state level. Table 3 shows the three top and three bottom rated system of care components existing in communities and the state.

Table 3: Top three and bottom three system of care components for community and state

	Community	State
Top Three Components	1. There is a strong effort in my community/area to redeploy funds from higher cost to lower cost services 2. There is an appropriate array of services for children and families in my community or area 3. Workers are trained to effectively respect and work with children and families in my community	1. There is a strong state effort to redeploy funds from higher cost to lower cost services 2. There is a formal interagency State level team for joint decision making across child-serving systems 3. Agencies work together to ensure services for children and families are culturally and linguistically appropriate (state level)

Bottom Three Components	1. There is a clear and feasible plan for sustaining fiscal support for children and family services in my community/area 2. There is a local social marketing/strategic communication plan to inform people about the system of care 3. In my community/area, youth are influential partners working with agencies to decide youth/family policies	1. The State has an effective approach to coordinate funding across child serving systems 2. There is a clear and feasible plan for sustaining fiscal support for children and family services in Nebraska 3. An appropriate array of services for children and families is available statewide

Survey participants were asked to identify and rate the system of care service components that were strengths and needs in their communities and at the state level. Table 4 shows the three top ranked strengths and needs for communities and the state.

Table 4: Top three rated strengths and needs for communities and the state

	Community	State
Strengths	1. Focus on early intervention 2. Focus on prevention 3. Broad array of effective services	1. Focus on early intervention 2. Strong family advocacy groups 3. Focus on prevention
Needs	1. Accessible services 2. Broad array of effective services 3. Focus on prevention	1. Accessible services 2. Maximize federal funding 3. Broad array of effective services

The community results indicate survey participants feel most positively about the prevention efforts, the array of services in their communities, and the professionals who provide those services. Although these system of care components are seen as relative strengths, survey participants indicated they also are areas of greatest need and require enhancements. Hence, although prevention and a broad array of effective services are seen as strengths, these components are also identified as being priorities for improvement. The indication that service accessibility is the top priority need may indicate that although services exist, youth and families may not be able to access them (the complete list of community strengths and needs can be found in Appendix 4, Table 4.3).

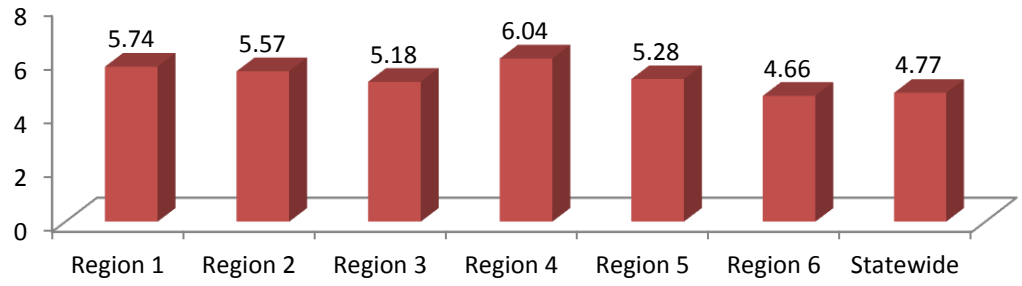
For the state results, it may not be surprising that a formal state-level team for joint decision making was rated as the system of care component most likely to exist, since many of the survey participants were aware of Nebraska's System of Care (SOC) Expansion initiative, which includes an interagency team. The SOC initiative has attempted to include diverse stakeholders in the planning process and includes core strategy teams. Hence, the relatively high rating of the

top three items may reflect the current planning initiative. The biggest areas of need as identified by participants are to coordinate, sustain and maximize funding and to develop an array of accessible services (the complete list of state strengths and needs can be found in Appendix 4, Table 4.4).

There were significant differences in system of care ratings among different groups of survey participants. Family members tended to rate the overall Nebraska system of care higher than youth and providers, but tended to rate individual system of care components lower than did the other two groups (these differences are discussed under the 10 core strategies below).

There were significant differences in ratings based on area of the state. Participants from Region 6 gave the Nebraska system of Care the lowest rating, and participants from Region 4 gave the system of care the highest rating ($F(6,742) = 3.755$, $p < .001$). Figure 2 shows the ratings. There were also significant differences across region in the ratings of system of care components and the rankings of strengths and weaknesses at the community and state levels. These results can be found in Appendix 5.

Figure 2: System Rating by Area



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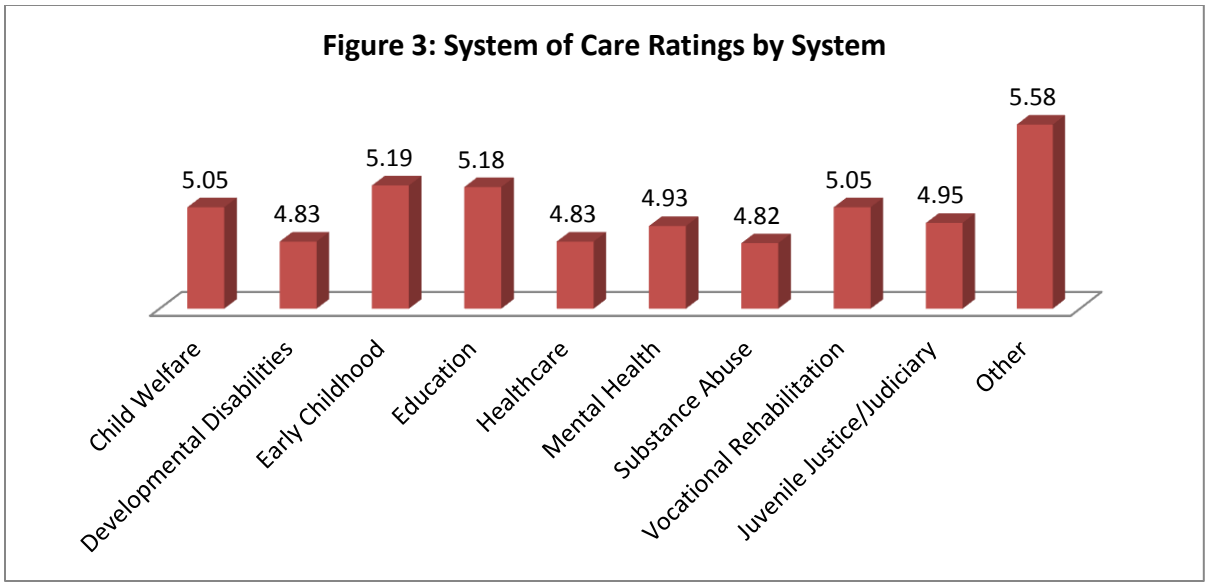
Participants from other systems and from the early childhood system tended to rate the system of care higher; participants from substance abuse, developmental disabilities, and healthcare tended to rate the system lower (see figure 3). In addition, the longer a participant has been involved in the system of care, the more likely that individual is to rate system of care components lower. Differences in rating of system of care components across youth-serving systems can be found in Appendix 6.



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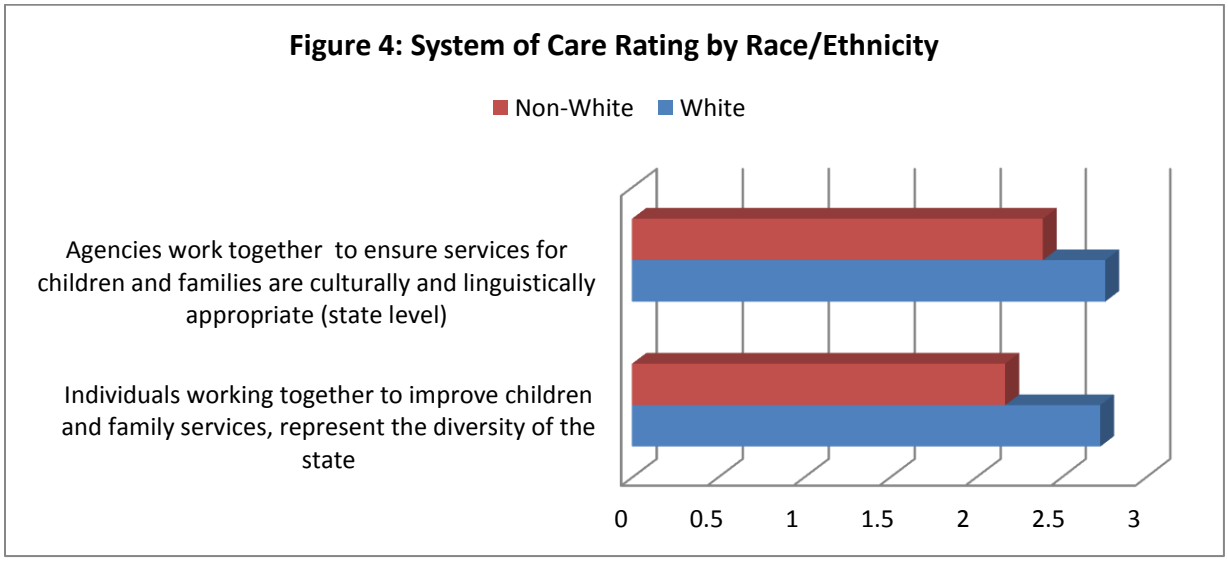
There were also differences in ratings based on race and ethnicity. Participants who were white, non-Hispanic rated components related to cultural and linguistic competence higher than minority groups (see Figure 4). Minority participants were less likely than white-non-Hispanic participants to identify "families partnering on policy decisions" to be a community strength and more likely to identify "accessible services" and "culturally and linguistically appropriate services" as community needs.

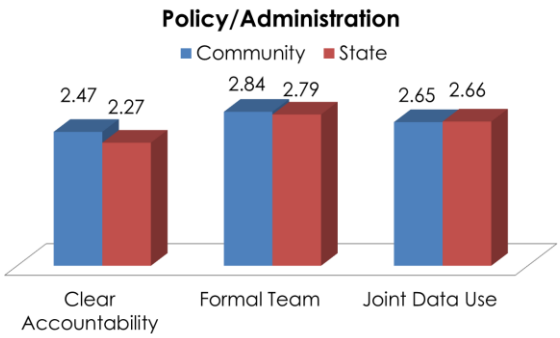


Ratings range from "1" (strongly disagree component exists) to "5" (strongly agree component exists); an average of less than "3"indicates on average participants believed the component does not exist.

POLICY/REGULATION

Survey participants thought clear accountability for decisions, formal interagency teams that make decisions, and joint use of data for decision making is lacking at both the community and state levels. Community ratings were slightly higher than state ratings. Family members tended to rate all items at the community level lower compared to ratings from other respondent groups.

Figure 5: Ratings of policy components



Participants made comments in the survey and discussion forums about policies, administrative practices and regulatory issues. The first area centered on participant desires for state agencies to model the type of collaboration needed to make systems of care work. Many of the comments were either critical of or encouraging more collaboration within the Nebraska Department of Health and Human Services. In particular there was a strong desire for increased participation in the system of care initiative by Medicaid and Child Welfare. There were also comments about the need for education and developmental disability systems to participate more fully.

"It has to start from the top. If the agencies at the state level aren't talking to each other, it is impossible for collaboration to occur regionally or locally."

Participants wanted to see state services implement the systems of care philosophy by using family centered practices and monitoring fidelity to evidence based treatments in state services (for example, limiting caseloads for child welfare workers). At the policy level participants want state leaders to provide the framework, data and resources for local implementation of systems of care. They cautioned state leaders to create policies that allow for creativity by local collaborations to meet local needs and to identify mechanisms to encourage and fund community collaboration development.

"There needs to be agreement about what the outcomes should be, but then allow communities to be flexible and creative to achieve solutions that work within their communities."

Participants want state systems to align and streamline administrative procedures so they are family friendly. For example, participants suggest the state create one shared intake process that does not need to be repeated across systems, create mechanisms for information among systems that respect confidentiality and consider one application covering all state funded programs (e.g., Medicaid, Food Stamps). There was an overall sense that efficiency was currently a priority over being family centered. Other suggestions from participants include making a live person available to talk with families when they call DHHS and reviewing procedures to speed eligibility determination in multiple systems at once. Administrative procedures were viewed as

barriers to accessing services. Some recommend that systems discontinue perceived requirements of failure at lower levels of care before higher intensity services can be accessed.

Participants want service definitions, reimbursement rates and funding roadmaps reviewed and aligned. Most comments in this area reflected perceptions that reimbursement rates for service providers by Medicaid was too low and not supportive of evidence based practices. This was coupled with a desire for private insurance to cover child mental health and developmental services more fully.
"Medicaid has made it difficult for low income families to find high quality services. Many providers do not accept Medicaid families due to low reimbursement rates."

Participants suggest that Medicaid reimbursement rates and covered services be reviewed to ensure they cover effective practices and reimburse providers appropriately. Specifically participants want the state to create a policy and practice of reimbursing providers for participation in team meetings. In addition, suggestions were made to review eligibility, stop dates and rules for state funded or Medicaid services for children and youth across systems and to identify gaps and contradictions among system procedures and rules with families at the table.
"Insurance and program eligibility shouldn't dictate if my kid gets help; if they need help why can't there be one organization that provides it, period."

Many participants are in favor of creating shared mechanisms for flexible funding of support resources across systems. They recommend that service development of prevention, early intervention and crisis services for children and youth be prioritized by policy makers along with policies that support EBPs for Autism spectrum disorders.

Before evidence based programs can be fully implemented, participants believe workforce capabilities to use them must be enhanced. They suggest policy makers identify preferred evidence based practices and coordinate with funders to ensure these practices are covered. They suggest the state create incentives for provider adoption of evidence based practices. Participants want the state to investigate why there is such a high turnover of caseworkers and create an administrative and regulatory environment to support and retain good workers. Participants view the state as having a responsibility to identify and implement common education/training for everyone working in child serving systems and to instill a culture of customer service and family centered practice in all state funded systems. This was coupled with a desire for education system standards for safety, working with children who have complex behaviors and team meetings (family centered).

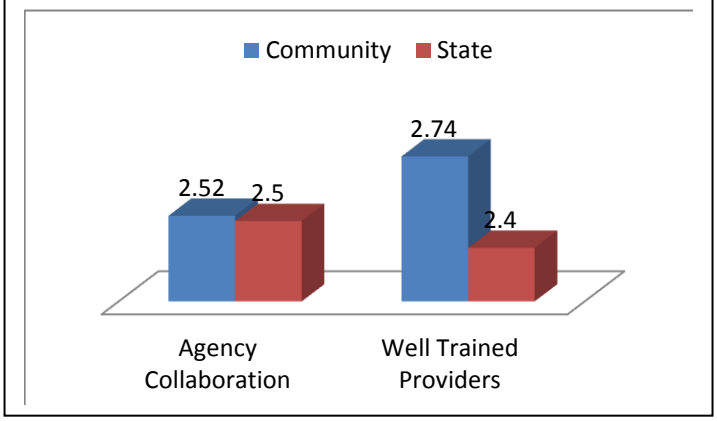
Once systems of care policies are being implemented, participants said they want the state to create system measures that are transparent, accessible and used for system adjustment. This includes fidelity monitoring and collecting and aggregating data around performance measures

across systems. There is an expectation that shared data points across systems will be created and common system measures will be used across child serving systems (including schools). Participants want to see both quantitative and qualitative measures of system development monitored and provided to communities. Community members want feedback and transparency in system monitoring (for example with the current DHHS/Probation changes, on policies implemented to combat bullying in schools, and disproportionality in juvenile justice).

Trauma-Informed Care

Survey participants thought there was a lack of interagency collaboration to promote trauma informed care and efforts to train providers in trauma informed care. Participants tended to think there were more efforts to train providers on trauma informed care at the community level than at the state level. Family members were more likely than providers and other stakeholders to rate these system of care components low at both the state and community levels.

Figure 6: Ratings of Trauma-Informed Care



Survey comments and discussion forums revealed there was a general consensus that a common understanding of trauma was needed across systems.
"Early intervention, and education and training are key, and say trauma is trauma not just bad behavioral and what trauma causes"

Participants suggested that the state use a common curriculum to educate professionals in all systems about trauma (child welfare, education, behavioral health, and medical/health). Additional education was also suggested for families and the public about how trauma impacts people across the age span.

Participants want practices that are trauma informed systematically implemented in all systems. Many noted they had training about trauma but were still trying to figure out how to implement what they learned, so suggestions were made to identify and promote specific evidence based practices that are trauma informed for schools; foster parenting; court/justice; medical; child welfare; law enforcement; and clinical settings. It was also suggested that fidelity to EBPs be monitored and that common assessment tools be used to create a shared understanding of trauma impacts that can be shared across systems. Participants want all systems to review their current administrative practices to ensure they are trauma sensitive (e.g., conducting investigations)

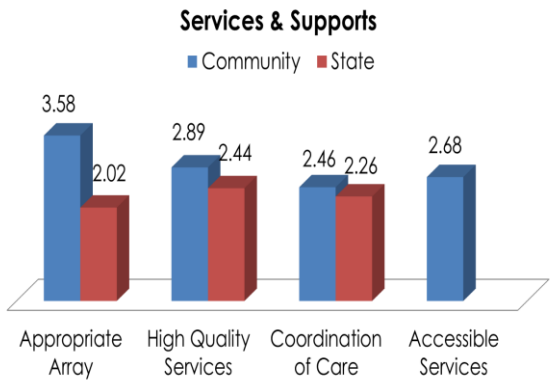
"We've have the training but how do we help each other operationalize that?"

Another widespread concern for participants is to create and implement systemic plans to address and prevent secondary/vicarious trauma of workers. They suggest the state assess potential trauma impacts of institutional or system change prior to implementation and disseminate best practices for prevention of vicarious trauma across systems.

SERVICES AND SUPPORTS

Survey participants perceive that service and support components were lacking at both the state and local levels including high-quality services, coordination of care, and accessible services. Participants indicated an appropriate array of services for children and families exists in their community, but not at the state level. Family members rated the community array of services higher but all other service and support components at both the state and local level lower than did providers and other stakeholders.

Figure 7: Ratings of Services & Supports



Survey and discussion forum participants voiced an overall perception that we need more of all services and supports.
"We have NO Treatment Services in this area so children are sent far away from their families and parents are expected to travel, that have no money, to participate in treatment with their children."

Although there was agreement that support services must be part of a service array for families, there was a difference in the type of supports desired by families and professionals. Families and youth want to build strong informal support systems such as support groups and extracurricular activities for children and youth, but few professionals made such comments. Both families and professionals want more formal support services like age-based mentors; supervised places for teens; and formal Youth and family advocacy
"Community treatment aides for juveniles are placed on probation for their parents who have a mental health or substance abuse issues"

Many participants noted that transportation is a problem in rural and urban areas. Participants said that services and supports are not always close to home and require travel to either attend or deliver them. Few if any transportation supports are available, especially in rural areas.
"Some families do not have the means to travel 5-20 miles to get the help they need, nor do they have schedules that allow them to go in the evenings."

Participants said that focused support is needed at transition points for youth (Middle School/High School/adulthood). These points were viewed as critical developmental milestones that children and youth with complex problems don't always negotiate well. Suggestions for increased services and supports at these points include mentors (Peers and adults); support groups; supported employment; and independent living support including housing.
"Build two tier independent living project for youth who are not system involved. There is not housing for them unless they are a state ward or in trouble. "

Families and professionals both advocate for more education on parenting including the "swarming signs of troubled youth before too late", recognizing depression, and managing behaviors. Although professionals want to support families, they also want "accountability standards for parents" that are part of service system requirements.
"We need services that work with parents - even when they don't want to…There needs to be some sort of requirements for parents when students are failing, have severe behavior and emotional issues."

Families, professionals and some youth want to locate services/supports in schools. Schools are viewed as convenient, low stigma locations for families and youth that are often in areas close to where families live. Participants did not advocate for schools to become service providers, but did believe schools were ideal places for services to be located and made available.
"Embed services for youth into the schools rather than expect families to access services on their own."

Participants did want educational systems to have the resources they need to keep children with complex needs in school at all ages. A frequent suggestion for keeping kids in school was to hire social workers or counselors to consult with teachers and families.
"If funding were available, I think an excellent improvement in child services would be to place a full-time, highly qualified social worker and child counselor in each Title I school and half-time ones in each non-Title I school."

Participants believe costs and reimbursement rates limit accessibility of services and supports. Many expressed the view that the Medicaid reimbursement rates for specialized child services is too low and that additional flexible funding is needed for families to access the support services they need.
"Insurance is an issue; providers complain the requirements for Medicaid is terrible so they stop seeing youth."

Participants identified a number of gaps in the service array for children and youth. Generally, participants said that child/youth crisis services are underdeveloped across the state. A frequent

concern was for development of crisis services that include in-home stabilization and 24 hour availability of crisis teams for assessment and consultation for families and law enforcement. *"Have crisis teams to respond to families in crisis then route them to the services they need, medical, behavioral, school, I would want funding to help develop that system because it would be a good support for every system sitting here, that early intervention is crucial."*

Families said there is a need for more affordable respite services for teens with severe behaviors. *"Trained and affordable respite for older children with mental illness/behaviors. Just because a child turns 12, the families still need respite care."*

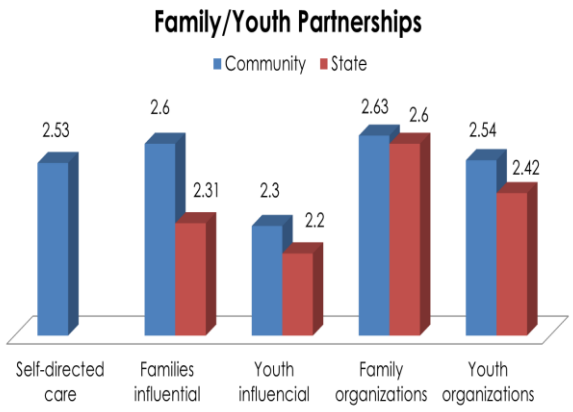
Participants perceive that intensive outpatient programming options for youth are not available in many areas of the state in mental health or substance abuse service systems. Participants specifically identified day treatment (partial hospitalization) and similar programming as lacking in many parts of the state.
"Intensive counseling services that work with not only the child but the entire family and don't quit after 90 days."

Other service gaps identified by participants include child psychiatric services; more quality residential services to serve youth with severe behavior disorders and addictions; evidence based services (MST) are not readily available in all parts of the state; and specialized population specific services are not accessible (juveniles who have experienced sexual assault and sex trafficking, services for young sexual aggressors, teen mothers and their children, gang members, children with reactive attachment disorder (RAD), Autism spectrum disorder, traumatic brain injury, youth with drug abuse problems, co-occurring disorder, or youth in detention.)

Family and Youth Partnerships

Survey participants perceive family and youth partnership components as lacking at both the state and community level. This includes the ability of youth and families to direct their own care, families and youth being influential partners working with agencies, and having strong youth and family organizations. Ratings for family and youth partnership components tended to be higher at the community level than at the state level. Family members rated the existence of state youth organizations significantly lower than did other participant groups.

Figure 8: Ratings of Youth/Family Partnership



Comments revealed that families believe professionals don't communicate with them well while providers and stakeholders repeatedly pointed to communication as their strength. Families want to be involved in team meetings and want them scheduled at times they can attend. Families believe professionals see things only through their own lens and that intervention is often "blame based". They want professionals to recognize that often the family system is under stress and that there is a power differential in the team meetings that naturally limit the family voice in that setting. They believe tolerance and understanding is needed to work well with families.
"Truly involve the parents in the planning, don't assume they are bad parents. …Stay with the family for a longer period of time… The family should have feedback as to how long they are worked with, instead of being told – we think you are doing great so we are going to complete your plan, is that okay?"

Some parents commented that they try to protect youth by excluding them from team meetings if they believe it is not going to helpful for the youth or family system.
"Parents keep kids out because if the meetings aren't strength based there is a reason the youth isn't there. "

Some providers commented that some parents aren't ready to advocate for child's best interest so parental accountability is important.
"Some parents don't want better things for their kids. Some parents don't want to look bad. Parents expect systems to fix kids. Parents need to understand their responsibilities and how to raise their kids."

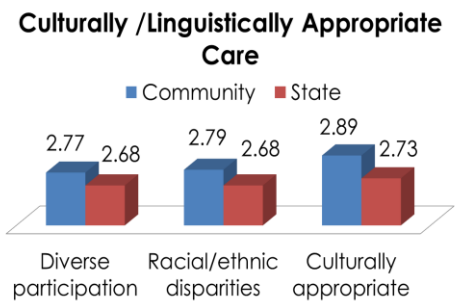
Professionals working in schools believe they should be involved in teams because they often work with children most of the day and may have information parents do not have.
In general participants want to increase opportunities for system level involvement for youth and families. Some participants cautioned against relying solely on family organizations to represent all families and all youth.
"It appears that one or two families and one youth represent the "family" and "youth" voice at all meetings (I see the same person or two people) which is not a fair or accurate representation. There is not a good mechanism for sharing the consumer/family perspective."

Many commented on the need to equip family members and youth so they know how to participate at the system level. They noted that community collaborative meetings should be held when families/youth can attend which is often outside of normal business hours. Youth face extra barriers to involvement. Youth participants noted that they are not always taken seriously at team or system level meetings. A barrier for transition age youth participation is that their basic needs must be met before system level involvement can be expected.

Culturally and Linguistically Appropriate Services

Survey participants thought cultural and linguistic appropriate care components were lacking at both the state and community level including diverse participation of individuals working together to address system of care issues, agencies working together to address racial and ethnic disparities in services, and working to ensure services are culturally and linguistically appropriate. Ratings at the community level tended to be higher than at the state level.

Figure 9: Ratings of Cultural/Linguistic Care



Generally all participants were aware of a need to address cultural and linguistic competence in systems of care. However some participants advocate for a shared understanding of what that means.

"I'm not even sure we even have a good definition for cultural and linguistic competence"

Participant comments reflect a desire for systems to recognize that culture is more than race and ethnicity; participants noted it includes Gender; Poverty; LGBT; Family culture; and Religion. Rural residents were specifically concerned that rural and frontier culture is recognized in addition to the more urban culture in Nebraska's largest cities. Some participants talked about culture specific to different systems and its impact on how professionals work together and with families (courts; mental health; substance abuse; child welfare).

"When you try to get funding they want you to be culturally competent but funders don't recognize rural/frontier culture."

Participants offered suggestions to prepare the child serving system workforce to work with diverse cultures. For example, many comments were made about the need to attract, develop and retain bilingual provider staff, especially Spanish.

"Hiring bilingual bicultural workers is hard because they don't always test or interview well. We need to dig into references to find out who a person really is."

"For us to hire bilingual staff is really a training period for others to hire them away from DHHS."

Another large area of concern is to develop professional interpreters (including sign language) with knowledge of systems and cultures. Additionally, providers need education about how to effectively use interpretation service with children, youth and families.

"Interpreters need to be trained in mental health world and should address their secondary trauma."

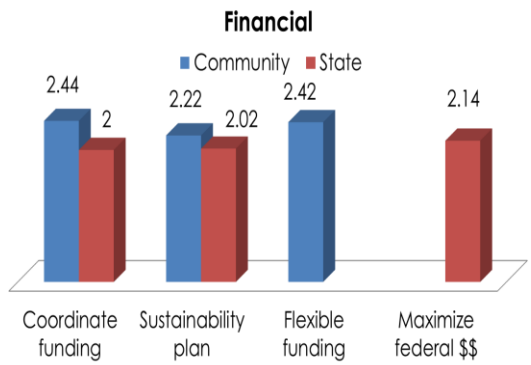
Providers and family members note that cultural issues impact understanding of mental health for workforce members. This comes into play when urban professionals are linked to rural areas via tele-medicine; and when international professionals join the Nebraska workforce.

Some participants want to make sure that diversity is incorporated in system planning, implementation and evaluation. This includes use of data to drive decisions about disproportionate service in all systems and ensuring Nebraska's diversity is represented in planning bodies at the state level.
"We don't involve people of color in system building; takes a big effort to get a diverse voice and we will build another system that is again not capturing the diverse voice."

FINANCE

Survey participants believe finance components were lacking at both the state and community level including coordination of funding across service systems, use of flexible funding, having a clear and feasible plan for sustaining fiscal support and maximizing federal funding at the state level. Ratings at the community level tended to be higher than at the state level. Family members rated all community funding components significantly lower compared to ratings by providers and other stakeholders.

Figure 10: Ratings of Finance



Overall, participant comments regarding finance centered on the belief that more funding is needed for children's behavioral health services.
"More funding has to be infused - schools and providers can't absorb any more without additional resources and support"

Most recommend that plans for systems of care in Nebraska include ways to sustain funding over time rather than considering only one time infusions in the system.
"Often, after a couple years the funding goes away and is not sustained. The problem is it takes resources out of other programs while they are trying to meet the demands of the funded program."

Participants in all parts of the state strongly believe funding should be directed toward co-locating behavioral health services in schools.

"Look at how you can allocate funding and push services and trained providers and caseworkers into the school setting as a place for services to start. This is where we often identify the mental health needs, where we can monitor student growth, where we can begin to build relationships with families, where we can bring resources to isolated communities."

Many comments include the need for financing plans to make flexible funding available for formal and informal supportive services in addition to traditional treatment. Participants said that this is often an element of financing that is left out of funding or is not sustained.
"Would like to see some sort of flex funding be made available for youth/families before they enter in to costly systems of care."

Many comments, especially from providers, advocate adjusting policies and regulations to create funding streams supporting EBPs and system of care team participation. Many perceive that evidence based practices are supported in theory but seldom are there financial incentives made available to make their use financially feasible.
"If we don't have a lot of kids in a service the service may not have enough business to sustain it."

There were also comments about the need to adjust rules for authorizing services that are EBPs.
"Magellen doesn't approve when it deems it behavioral rather than mental health so it is hard to get payment for service authorized"
"Bruce Perry talks about treatments kids need to overcome trauma and at the same time Medicaid says they won't pay for it. Seems like one part of the state (bh) says it works and use it and Medicaid won't pay for it (EMDR; art therapy; play therapy)"

Participants made suggestions to help finance elements of systems of care such as braiding funding streams so they follow the child; creating service coordination rates for providers; funding cross-system youth crisis teams; and aligning billing and administrative forms/procedures across systems (child welfare, regions, behavioral health and Medicaid). It was suggested that a common definition for medical necessity be adopted by all child serving systems to guide behavioral health authorizations. Some suggested that a single overarching group be formed with power to review and align system procedures; referee funding for children with needs that cross systems; and provide oversight for mapping fund usage across child serving systems.

Participants want low reimbursement rates across all systems to be addressed. Suggestions also include creating incentives for EBP use, team participation and provider investment in system coordination. Of particular concern in rural areas is a need to create a travel reimbursement rate for providers.

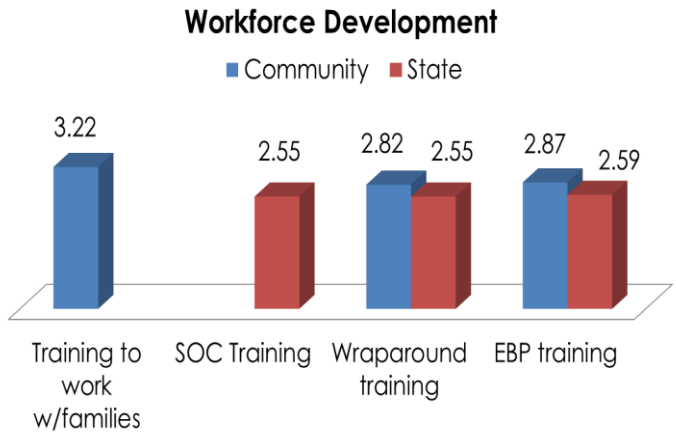
"Lack of funding for providers to take the time to build relationships with families that have high trauma and stigma needs. Lots of work that needs to be done on non-billable time"

Families caring for children and youth to keep them out of foster care lament about the difference in compensation for them versus foster parents. They recommend incentivizing family care over foster care.
"If a child goes into foster care they would have received somewhere between 700-1000 a month compared to 200 for families."

WORKFORCE DEVELOPMENT

Survey participants said that workplace development components were lacking at both the state and community level including statewide system of care training, training workers to provide high-fidelity wraparound, and training professionals to provide effective evidence-based practices. Participants tended to believe there were efforts to train workers to effectively respect and work with children and families in their community. Ratings at the community level tended to be higher than at the state level. Family members rated community wraparound training and community and state evidence based practice training lower compared to ratings by providers and other stakeholders.

Figure 11: Ratings of Workforce Development



Comments and discussion forums revealed that across the state there was a general perception that Nebraska has a shortage of behavioral health professionals with expertise working with children/youth. Specifically we heard there were acute shortages of child psychiatrists, and therapists/counselors with specific expertise in Evidence Based Practices (EBPs) for children and youth. Participants note that school social workers are underutilized and that DHHS should use more qualified social workers within the child welfare system. Many other specific professions were mentioned by participants as being unavailable or with limited availability across the state (substance abuse treatment professionals with expertise working with children and youth; providers with expertise working with co-occurring problems; Autism spectrum specialists; foster parents to care for children with complex behavior problems; family/youth peer advocates.) A common theme was also the need for a more diverse workforce in all child serving systems.

One potential cause for workforce shortages echoed by many participants was the perception that compensation of providers specializing in work with children is too low.
"You can teach the skills of high-fidelity wraparound to anyone, but there are workers that are truly skilled providers that are severely underpaid and overworked. This causes workers to leave the field and leaves families, agencies and youth at a loss."

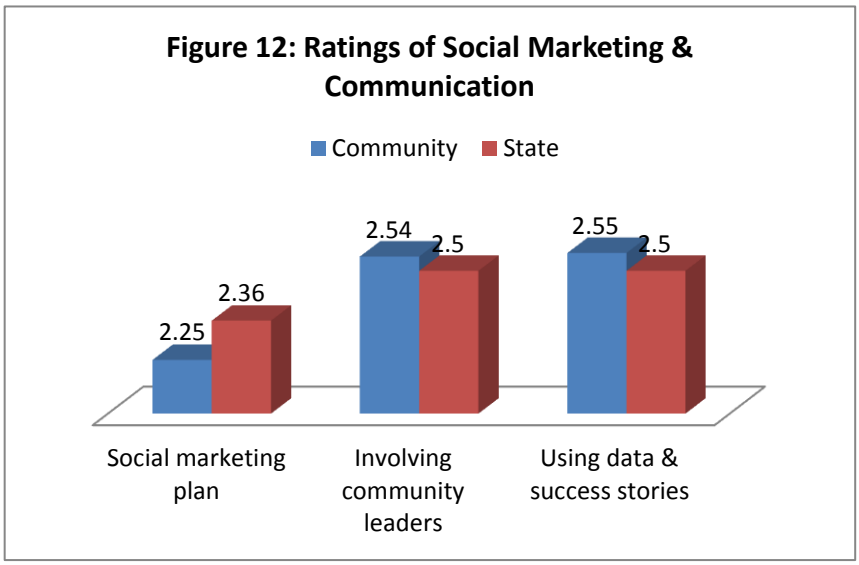
Participants want the state to encourage use of evidence based treatments by paying for development of capacity and to create financial incentives for service providers to use EBPs. Additional suggestions from participants include adjusting rates or creating reimbursement for "windshield time" for rural/frontier providers; creating financial incentives or rates for participation in coordination teams and creating financial incentives to attend or obtain education about EBPs.

Families want the workforce in child serving systems to be informed, understanding and available. A number of comments suggested that education for providers was a way to create what families need professionals to know. They said that education for all professionals in child serving systems should include the topics of trauma, social/emotional development, screening for problems, family centered practice and active listening (to enhance understanding). Additionally, the workforce needs to be prepared to participate on teams so participants suggested regular education about system of care and high fidelity wraparound principles along with cross-training among the workforce so they understand system roles and capabilities (for example, child welfare workers should understand treatments; law enforcement should understand wraparound etc.) Families want to promote coordination and referral by fostering a workforce that embraces the "no wrong door policy." Additionally, youth and family want providers who understand culture and who are available when needed (including weekends and evenings).
"We are in desperate need of professionals such as psychiatrists, therapists, social workers, teachers, advocates, doctors, and nurses that are knowledgeable in the diversity of each culture and their beliefs along with the family dynamics."

Many comments were made about the need to develop workforce skills to ensure specialty treatment and intervention is available when needed. Participants want to encourage and fund competency based training to create expertise for provision of crisis intervention; in-home therapies; school based therapies; evidence based practices like Multisystemic therapy, applied behavioral intervention, wrap around; behavioral interventions versus mental health interventions; and working with specific populations or issues like gender (working with girls, LGBT issues, gender identity), sex trafficking and sexual assault, teen mothers, gang prevention/education, Reactive Attachment Disorder

Social Marketing and Communication

Survey participants thought communication and social marketing components were lacking at both the state and community level including having a social marketing/strategic communication plan to inform people about the system of care, involving key community leaders to communicate about the system of care, and using data and success stories to communication about the system of care. Ratings at the community level tended to be higher than at the state level except for having a social marketing plan, which was rated higher at the state level. Family members rated involving community leaders significantly lower and youth rated having a marketing plan and involving state leaders significantly lower compared to other participant groups.



Participant comments generally support a public awareness campaign emphasizing treatment success that is modeled after a public health approach.
"Lack of awareness – mental health doesn't share success and things that work so people know that things work."

Several suggestions were made about creating awareness material that is clear, direct and understandable. Participants want to see a campaign using positive language and stories to educate public about mental illness. Families and youth want to be equipped with skills to help tell their stories as part of a campaign to educate the general public about what a system of care is. It was recommended that champions and culture brokers be enlisted to help carry these messages.

Many participants recommended that general awareness campaigns be augmented with education specifically about how to keep children and youth safe. Families want concise information about suicide, safety and managing crisis behaviors including information to help families ask questions of professionals to help them keep their children and youth safe. Helpers want information to help with them assess behaviors and make appropriate referrals. Families want helpers to know how to manage serious behaviors and how to keep children and youth safe.

Overall families and professionals want any social marketing campaign to address stigma. Families and youth fear being labeled because they believe the general community has preconceived negative ideas about who mental illness affects. Messages should emphasize that mental illness can be in any Nebraska family.
"Make services more known and break the stigma connected to mental illness so that you don't feel ashamed to get help."

Families believe that professionals also have negative preconceived ideas about the families involved with child welfare and behavioral health systems, so some part of an anti-stigma campaign should be directed at the child serving system workforce.
"Most agencies look down their noses at our clients."

Families and professionals believe that both groups have a misunderstanding of services and who they are for, which limits referrals and utilization rates.
"We have a lot of stigma around what it takes to access services for families, and in turn we have underutilized services, but we have family programs for anyone whether youth have mental health diagnosis or not, and we had 3 referrals last year."

Participants believe real system change will not occur unless legislators are also educated about mental health and stigma.

Another central component of any communication plan as identified by participants is to market where and how to get help. Families want a single person, place or location to get information about behavioral health conditions, resources/treatment options, eligibility for resources, and how to access them. Professionals want information about services to help educate families about local options. Participants said they want information that is simple, easy to understand and with positive language to instill hope.

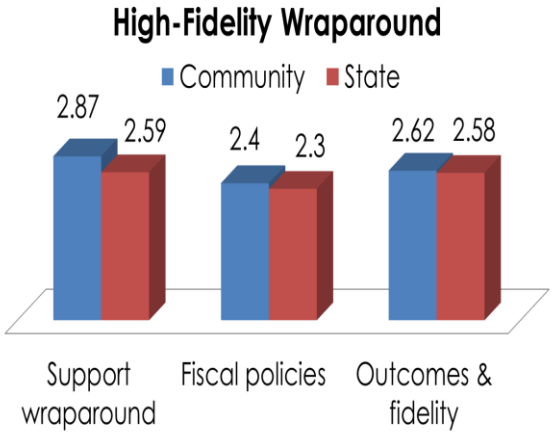
Participants also said that marketing should contain a specific plan to reach at-risk families, especially culturally and linguistically diverse families. Participants noted that multiple modes of marketing are needed to reach families
"We are all grouped together because we have children with mental health issues the best way to reach us is a variety of ways so some families that you may not reach can be reached. We are individuals and need to be related to on a case by case basis."

To reach at-risk families it was recommended that outreach be personalized locally when possible and natural gathering places for families and youth serve as places where messages are made available (schools; sports; activity centers; physician offices). Participants also want to equip helpers with information for at-risk families

HIGH-FIDELITY WRAPAROUND

Survey participants perceived that high-fidelity wraparound components were lacking at both the state and community level including working in partnership to support high-fidelity wraparound, tracking outcomes and fidelity to improve wraparound, and having fiscal policies to support wraparound. Ratings at the community level tended to be higher than at the state level. Youth rated involving community wraparound support and state and community fiscal policies significantly higher compared to other participant groups.

Figure 13: Ratings of High-Fidelity Wraparound



High fidelity wraparound was not a familiar phrase to many participants so comments related to wraparound were related to specific components of wraparound. For example, participants generally advocate for more support to develop local interagency teams. They want local teams to have the flexibility to identify services and supports needed in their area and not have them dictated by state level teams.

"By NE assuming on a state or policy level that they know what each community needs, a gross generalization is being made that contradicts the implementation of high fidelity wraparound. Provide the framework, tools, data on a state level. Distribute that to communities with specific expectations and timelines for implementation. For communities that do not have a formalized interagency team- pull individuals from communities that do to help them first build their collaborations. Do not expect every community or region to progress at the same rate"

Some participants commented on the need to adjust service definitions for wraparound to ensure it is available for families when needed (for example for ages 3-9). Some also advocated for high fidelity wraparound to be identified as a direct service that was available for all income levels.

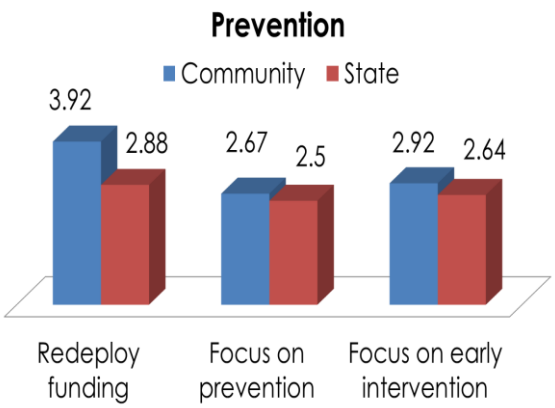
"When working with a family to improve all aspects of life, the wrap around partner should NOT have a stop date for care. The families ask for support when their lives are in shambles. To lose the support, only adds more trauma to an already volatile situation."

Wraparound and family centered practice was viewed by many as the same thing. They advocated for consistent implementation of the same training for family centered practice across all child serving systems. Additional education in facilitation was also desired for members of child and family teams.

PREVENTION

Survey participants tended to rate prevention components higher than other system of care components, although most still thought prevention was lacking at both the state and community levels including focusing on prevention, focusing on early intervention and redeploying funds from high-cost services to lower cost services at the state level. Participants rated the deployment of funds from high cost to low cost services at the community level as the highest rated system of care component. Ratings at the community level tended to be higher than at the state level. Family members rated community prevention and early intervention components significantly lower compared to ratings from other participant groups.

Figure 14: Ratings of Prevention



Participants generally believe Nebraska should fund and promote more preventative services. *"This will require a paradigm shift in mindset and focus away from reacting and towards proactive policies beginning with an emphasis on early childhood and family support through community based strengthening efforts."*

Many participants suggest prevention programs be located in schools and medical settings. Community members with experience or knowledge of Nebraska Children and Families Foundation local community initiatives suggest they be replicated across the state and that early childhood providers (such as Head Start) be included in community collaborations. Generally participants would like prevention funding to be focused on early childhood or prevention programs focused on risky behaviors for youth (suicide, substance use, safety, bullying.) Participants note that prevention must include education for professionals to promote social/emotional development in children and promotion of a culture that values education to prepare adults to be parents. Many participants suggested we prepare mentors to work with children with complex problems and create support networks for providers and families working with high risk children and youth.

Participants would like to see the system of care build and fund an array of early intervention services. They recommend promotion of early childhood screening and behavioral health assessment but suggest the state first address barriers to sharing assessment data among child serving systems. Participant comments support colocation of mental health and primary care and screening children and youth regularly for developing behavioral health issues. They believe

early intervention includes ensuring wraparound services are available to families with young children, promotion of EBPs for use in early childhood in a variety of settings (school, daycare, home) and ensuring these EBPs are reimbursable services (Medicaid; Magellen.) Participants suggest the state address limits on eligibility and number of covered services/visits for young children and subsidize development of EBP capacity for providers and schools.

Summary and Conclusions

There was good participation in the system of care survey and discussion groups conducted across the state. There were 783 individuals who participated in the survey and 319 participants in the discussion groups. Participants perceive that most system of care components were lacking in communities and all components were lacking at the state level. Participants identified the components most likely to exist in their communities as: 1) redeploying funds from high cost to low cost services, 2) an appropriate array of services, and 3) workers trained to respect and work with youth and families were the. Components most likely to exist at the state level were identified as: 1) a formal interagency team, 2) agencies working to ensure cultural and linguistic competence, and 3) individuals working to improve services reflect the diversity of the state were the

Participants perceive the greatest community strengths as focuses on early intervention and prevention, and a broad array of effective services; but interestingly prevention and the service array were also identified as the greatest community needs. Participants identified accessible services as the highest priority need for communities. Similar to community strengths, participants identified the greatest state level strengths as focuses on early intervention and prevention. Additionally they identified strong family advocacy groups at the state level as strength. Participants thought the greatest needs at the state level were accessible services, maximizing federal funding, and a broad array of effective services.

Ratings of system of care components and ratings of strengths and needs varied by participant groups, indicating the Nebraska system of care may work better for some groups and not others. Family members tended to rate system of care components lower than did providers and other stakeholders. Responses also varied by geographic area, service delivery system, length of involvement in the system of care, and race/ethnicity.

Participants indicated policy/regulation components were lacking at both the state and local levels, although these were not identified as high areas of need. Participants indicated the state should model the system of care approach by implementing family centered practice, flexible funding and monitoring fidelity to evidence based treatments. They expected state leaders to provide the framework, data and resources for local implementation of systems of care.

Participants believe trauma-informed care components were lacking at the community and state levels, and these components were identified as high need areas. Suggestions include use of a common curriculum for training, systematically implement trauma informed care across systems and monitor fidelity to evidence based trauma informed care practices.

Participants believe services and support components were lacking, although they tended to indicate their communities included a broad array of effective services. Service and support components were identified as areas of high need both at the community and state levels. Participant suggestions include developing a broader array of services across the state, developing more informal support systems for families and youth, enhancing transportation in both rural and urban areas, developing more school-based services, enhancing funding for crisis services, and developing reimbursement rates that support evidence based practices.

Participants thought youth and family partnership components were lacking across the state, although they indicated strong family organizations as a strength at both the community and state levels. Families indicated they want to be recognized as equal partners on child and family teams. Participants suggested increasing opportunities for system level involvement for youth and families and equipping them with the skills to participate effectively in policy development.

Participants perceive culturally and linguistically appropriate service components as lacking at the state and community levels. Minorities were more likely than non-Hispanic white participants to view these components as lacking and as a priority need. Suggestions include developing a shared understanding of cultural and linguistic competency, attending to the cultures of different service delivery systems, enhancing recruitment and retention of diverse professional staff and interpreters, and ensuring diverse representation in all aspects of system planning and evaluation.

Participants indicated finance components were lacking in communities and at the state level. Funding components such as maximizing federal funding and coordinating funding across systems were identified as high priority needs, particularly at the state level. Suggestions include increasing funding for children's behavioral health services, sustaining funding over the long term, enhancing funding for mental health services in schools, ensuring funding can be used flexibly for formal services and informal supports, and developing adequate reimbursement rates to support evidence based practices.

Participants believe workforce development components are lacking at the community and state levels, although they gave relatively higher ratings to "Workers are trained to effectively respect and work with children and families in my community." Training the workforce is considered a state and community strength as well as a priority need. There was recognition that Nebraska has a shortage of behavioral health professionals, particularly in rural areas. Suggestions include

better utilization of other system professionals such as school social workers, enhancing compensation for behavioral health providers to increase recruitment and retention, and improving the skills of the workforce through training on topics such as trauma-informed care, evidence-based practices, social and emotional development, high-fidelity wraparound, and cultural and linguistic competency.

Participants identified social marketing and strategic communication component as lacking in communities and at the state level. However, they did not identify these components as high need areas. Suggestions include modeling a public awareness campaign on a public health approach, enlisting champions and culture brokers in the campaign, focusing on specific populations to reduce stigma, recognizing mental health issues, providing information about access to care and increasing public support for children's mental health.

Participants believe high-fidelity wraparound components are lacking. Suggestions include increasing access to wraparound, ensuring teams have flexibility to access needed services and supports, and having a consistent model and training across systems to ensure broader implementation of the wraparound approach.

Although participants indicate prevention components were lacking in their communities and at the state level, they tended to believe prevention was more available than other system of care components. Prevention was considered both a strength and a high-priority need at the state and community levels. Suggestions include promoting more prevention services, locating prevention services in schools and medical settings, establishing an array of early intervention services (particularly those based on evidence based practices), and enhancing access by addressing limits on eligibility and limits on covered services.

APPENDIX 1: SURVEY

Nebraska System of Care Survey

This survey is part of a Readiness Assessment for the Nebraska System of Care Planning Project

The University of Nebraska Public Policy Center has been engaged by the Nebraska Department of Health and Human Services to conduct this assessment as part of a federal planning grant to prepare the state for systems of care.

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Nebraska System of Care Survey

Thank you for taking the time to complete this survey. The survey is designed to obtain information about systems that are currently in place in Nebraska communities to support children/youth with serious emotional disturbances and their families. You will be asked about system strengths and priorities for change to improve "systems of care." You will also be asked about an approach called "high fidelity wraparound."

System of Care

An approach in which many agencies at the state and local levels work together and in partnership with families and youth to develop youth-guided and family directed services for children and adolescents with multi-system needs. Systems of Care include:

- A full array of effective services
- Coordination of care across child-serving systems
- A community interagency team that includes youth and families that makes decisions to improve systems and services
- Improving training and capacity to provide culturally and linguistically appropriate services, and
- Coordination of funding to maximize resources across systems. A

System of Care also includes state and community agencies working together to improve services for youth and families. These agencies may represent mental health, substance abuse, child welfare, juvenile justice, education, medical care, public health, developmental disabilities and other systems.

High-Fidelity Wraparound

Sometimes referred to as Family Centered Practice or Individualized Care, this approach includes:

- A child and family team consisting of all the systems and agencies involved in care
- An interagency community team to do joint planning and decision making about development and implementation of wraparound
- Flexible funding to address the unique needs of each youth and family
- Plans of care that are coordinated across agencies and directed by families and guided by the youth
- Access to individualized services that are effective and informal supports provided by family members, friends, and community members
- A focus on monitoring fidelity to the wraparound process and achieving outcomes that are relevant to youth and families.

Teams in a System of Care

In this survey we refer to "teams" which are groups of people working together at different levels within a system of care:

Youth and Family Teams coordinate care for individual youth and families and may include all the different programs involved in helping them (e.g., mental health services, substance abuse services, schools, child welfare services, probation or juvenile services, mentors) as well as other family members, friends and informal supports.

Community or Regional Teams (often referred to as work groups) meet to coordinate funding and policies for services to all youth and families within a particular community or area. These teams include decision makers from many areas such as mental health, substance abuse, child welfare, education and child welfare. They may also include community leaders (including public, business and faith leaders), family members, youth and other constituency groups.

State Teams or work groups meet to coordinate funding and policies for services to youth and families across the entire state. These teams often include state agencies such as the Department of Health and Human Services, Department of Education, and Probation Administration. They may also include family members, youth, advocacy organizations, community representatives, and other statewide groups.

The answers you give to this survey will be combined with others so nobody will know which answers come from you. Please answer as many questions as you can.

The entire survey should take about 30 minutes to complete.

First, please tell us about you.

Q1:
Have you ever been involved in any way in any system involved with children or youth in Nebraska?

- ❍ Yes
- ❍ No

If you answered yes to Question 1, Please tell us which system(s) you are (or were) primarily involved in?

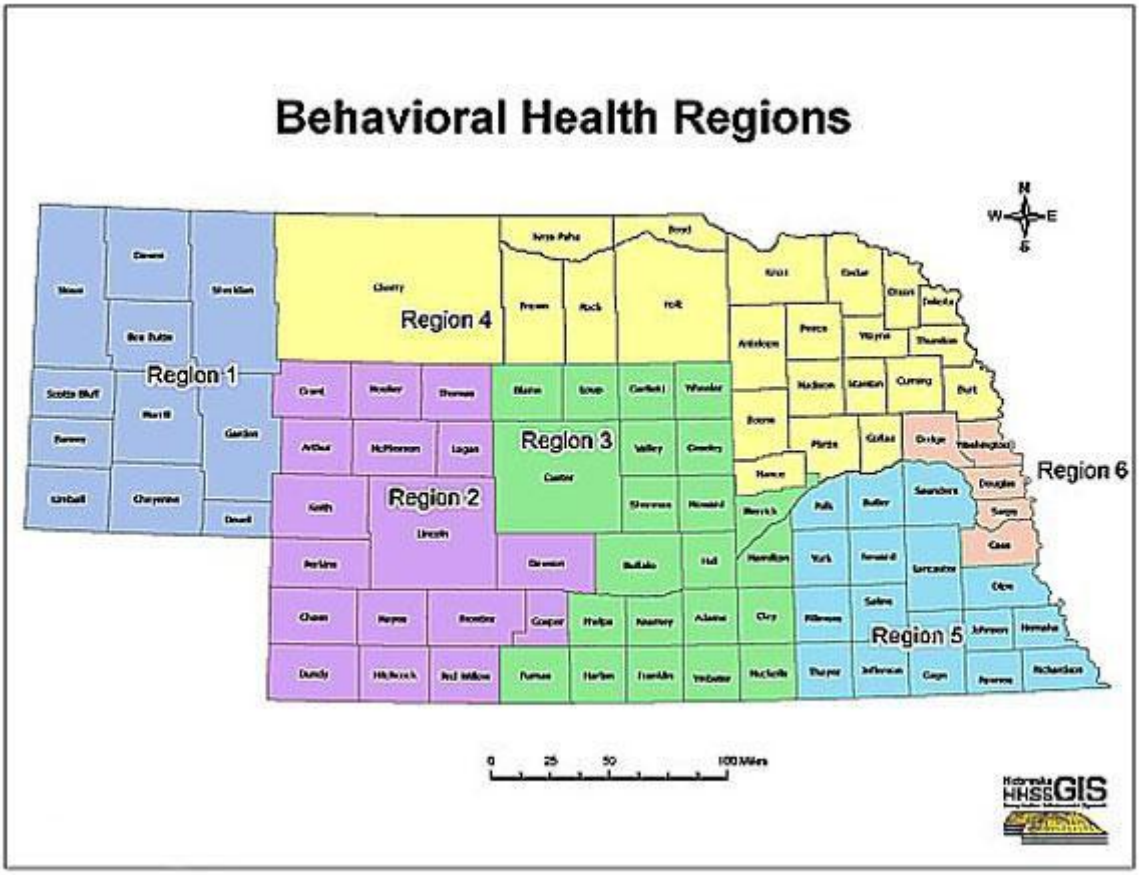
- ❑ Child Welfare
- ❑ Developmental Disabilities
- ❑ Early Childhood
- ❑ Education
- ❑ Healthcare
- ❑ Mental Health
- ❑ Substance Abuse
- ❑ Vocational Rehabilitation
- ❑ Juvenile Justice/Judiciary
- ❑ Other (Please Specify) _____

Q2:
What is your primary role?

- ❍ Parent/Family Member (past or present)
- ❍ Youth
- ❍ Foster Parent/Guardian
- ❍ Direct Service Provider
- ❍ Supervisor
- ❍ Administrator
- ❍ Teacher
- ❍ Judiciary
- ❍ Advocate
- ❍ Other (Please Specify) _____

Q3:
How long have you been involved, or were you involved, in the role you checked above?

- ❍ 0-4 years
- ❍ 5-9 years
- ❍ 10-14 years
- ❍ 15-19 years
- ❍ 20 years or longer



Q4:

Within which Behavioral Health Region do you Provide or Receive Services? (The map above shows the region boundaries - if you don't provide or receive services, click the choice for the area you live in)

- ❍ Region 1
- ❍ Region 2
- ❍ Region 3
- ❍ Region 4
- ❍ Region 5
- ❍ Region 6
- ❍ Nebraska State Level/Statewide
- ❍ State other than Nebraska

Q5:
What is the best way to keep you informed about system of care planning? (check all that apply)

- ❑ Email
- ❑ Social Media
- ❑ Texting
- ❑ Web Site
- ❑ In-person Meetings
- ❑ Other (Please Specify) _____

If you said that Social Media was the best way to keep you informed about system of care planning which social media do you prefer? (check all that apply)

- ❑ Facebook
- ❑ Twitter
- ❑ Pinterest
- ❑ Google+
- ❑ Linked In
- ❑ Other? _____

Q6:
In terms of racial background, how do you identify yourself?

- ❍ African American/Black
- ❍ Asian/Pacific Islander
- ❍ Caucasian/White
- ❍ Native American/American Indian
- ❍ Multiracial/Other

Q7:
In terms of your ethnicity, how do you identify yourself?

- ❍ Latino/Hispanic
- ❍ Non-Latino/Non-Hispanic

Q8:
Overall, what grade would you give Nebraska related to how the system works to help families with children and youth who have mental health or substance abuse challenges?

- ❍ A+
- ❍ A
- ❍ A-
- ❍ B+
- ❍ B
- ❍ B-
- ❍ C+
- ❍ C
- ❍ C-
- ❍ D+
- ❍ D
- ❍ D-
- ❍ F

ONLY ANSWER THIS PAGE IF YOU IDENTIFIED YOUR ROLE AS *Youth*
(Skip to the next page if you are not a youth)

Y1:
What is the best way to engage youth in system-wide planning?

Y2:
What current services and supports in your community/area are most helpful for youth with mental health and substance abuse challenges?

Y3:
What current services and supports in your community/area have been least helpful for youth with mental health and substance abuse challenges?

Y4:
What changes would you make to improve services and supports for youth in your community/area?

ONLY ANSWER THIS PAGE IF YOU IDENTIFIED YOUR ROLE AS *Family/Parent*
(Skip to the next page if your primary role was not family /parent)

F1:
What is the best way to engage families in system-wide planning?

F2:
What current services and supports in your community/area are most helpful for families of youth with mental health and substance abuse challenges?

F3:
What current services and supports in your community/area have been least helpful for families of youth with mental health and substance abuse challenges?

F4:
What changes would you make to improve services and supports for families in your community/area?

The next set of questions asks you to think about whether different conditions exist in your community or area. Take a moment before you begin and decide what community or area (county or regional area) you want to consider when answering them.

Tell us which community or areas you will be thinking about for the next set of questions:

Please tell us the extent you agree that the following policy/administrative components exist in your community or area:

Q9:
There is clear accountability for making community/area policy decisions for services to children & families

- ❍ Strongly Disagree
- ❍ Disagree
- ❍ Neither Agree nor Disagree
- ❍ Agree
- ❍ Strongly Agree
- ❍ I don't know

Q10:
My community/area has a formal interagency community team for joint policy decision making across child-serving systems

- ❍ Strongly Disagree
- ❍ Disagree
- ❍ Neither Agree nor Disagree
- ❍ Agree
- ❍ Strongly Agree
- ❍ I don't know

Q11:
Community/area agencies jointly collect or analyze outcome data to improve the quality of children and family services

- ❍ Strongly Disagree
- ❍ Disagree
- ❍ Neither Agree nor Disagree
- ❍ Agree
- ❍ Strongly Agree
- ❍ I don't know

Please tell us the extent you agree that the following trauma informed care components exist in your community or area:

Q12:
There is strong collaboration across agencies to plan for the needs of children and families who have experienced trauma in my community/area.

- ❍ Strongly Disagree
- ❍ Disagree
- ❍ Neither Agree nor Disagree
- ❍ Agree
- ❍ Strongly Agree
- ❍ I don't know

Q13:
Service providers are well trained in addressing the needs of children and families who have experienced trauma in my community/area.

- ❍ Strongly Disagree
- ❍ Disagree
- ❍ Neither Agree nor Disagree
- ❍ Agree
- ❍ Strongly Agree
- ❍ I don't know

Please tell us the extent you agree that the following service and support components exist in your community or area:

Q14:
There is an appropriate array of services for children and families in my community or area

- ❍ Strongly Disagree
- ❍ Disagree
- ❍ Neither Agree nor Disagree
- ❍ Agree
- ❍ Strongly Agree
- ❍ I don't know

Q15:
Coordination of care across services and systems occurs regularly in my community or area

- ❍ Strongly Disagree
- ❍ Disagree
- ❍ Neither Agree nor Disagree
- ❍ Agree
- ❍ Strongly Agree
- ❍ I don't know

Q16:
Services in my community/area are high quality

- ❍ Strongly Disagree
- ❍ Disagree
- ❍ Neither Agree nor Disagree
- ❍ Agree
- ❍ Strongly Agree
- ❍ I don't know

Q17:
Services are accessible in my community/area

- ❍ Strongly Disagree
- ❍ Disagree
- ❍ Neither Agree nor Disagree
- ❍ Agree
- ❍ Strongly Agree
- ❍ I don't know

Q18:
What additional services would be most helpful for youth and families in your community or area?

Please tell us the extent you agree that the following youth and family partnerships exist in your community or area:

Q19:
Youth and families are able to direct their own care by choosing services and supports that meet their needs in my community/area.

- ❍ Strongly Disagree
- ❍ Disagree
- ❍ Neither Agree nor Disagree
- ❍ Agree
- ❍ Strongly Agree
- ❍ I don't know

Q20:
In my community/area, families are influential partners working with agencies to decide youth/family policies

- ❍ Strongly Disagree
- ❍ Disagree
- ❍ Neither Agree nor Disagree
- ❍ Agree
- ❍ Strongly Agree
- ❍ I don't know

Q21:
In my community/area, youth are influential partners working with agencies to decide youth/family policies

- ❍ Strongly Disagree
- ❍ Disagree
- ❍ Neither Agree nor Disagree
- ❍ Agree
- ❍ Strongly Agree
- ❍ I don't know

Q22:
Families have strong advocacy organizations in my community/area

- ❍ Strongly Disagree
- ❍ Disagree
- ❍ Neither Agree nor Disagree
- ❍ Agree
- ❍ Strongly Agree
- ❍ I don't know

Q23:
Youth have strong advocacy organizations in my community/area

- ❍ Strongly Disagree
- ❍ Disagree
- ❍ Neither Agree nor Disagree
- ❍ Agree
- ❍ Strongly Agree
- ❍ I don't know

Q24:
Please tell us the extent you agree that the following culturally and linguistically appropriate care components exist in your community/area:

	Strongly Disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly Agree	I don't know
Individuals working together to improve children and family services, represent the diversity of my community or area (1)	❍	❍	❍	❍	❍	❍
Agencies work together to effectively address racial/ethnic disparities in service delivery (2)	❍	❍	❍	❍	❍	❍
Agencies work together to ensure services for children and families are culturally and linguistically appropriate (3)	❍	❍	❍	❍	❍	❍

Please tell us the extent you agree that the following financial components exist in your community/area:

Q25:
Agencies work together to effectively coordinate funding across child serving systems in my community/area.

- ❍ Strongly Disagree
- ❍ Disagree
- ❍ Neither Agree nor Disagree
- ❍ Agree
- ❍ Strongly Agree
- ❍ I don't know

Q26:
There is a clear and feasible plan for sustaining fiscal support for children and family services in my community/area

- ❍ Strongly Disagree
- ❍ Disagree
- ❍ Neither Agree nor Disagree
- ❍ Agree
- ❍ Strongly Agree
- ❍ I don't know

Q27:
In my community/area, flexible funding can be used to address the unique needs of each child and family

- ❍ Strongly Disagree
- ❍ Disagree
- ❍ Neither Agree nor Disagree
- ❍ Agree
- ❍ Strongly Agree
- ❍ I don't know

Q28:
Please tell us the extent you agree that the following workforce development components exist in your community/area

	Strongly Disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly Agree	I don't know
Workers are trained to effectively respect and work with children and families in my community	❍	❍	❍	❍	❍	❍
Workers are trained to effectively provide high-fidelity wraparound	❍	❍	❍	❍	❍	❍
Workers are trained to effectively provide evidence-based treatments	❍	❍	❍	❍	❍	❍

Q 29:
Please tell us the extent you agree that the following social marketing and communication components exist in your community or area:

	Strongly Disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly Agree	I don't know
There is a local social marketing/strategic communication plan to inform people about the system of care	❍	❍	❍	❍	❍	❍
Key community leaders are partners in efforts to communicate about the system of care	❍	❍	❍	❍	❍	❍
Data and family stories are used in communications about the system of care	❍	❍	❍	❍	❍	❍

Q 30:
Please tell us the extent you agree that the following high fidelity wraparound (family centered practice) components exist in your community/area:

	Strongly Disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly Agree	I don't know
People are working in partnership to support high-fidelity wraparound (family centered practice) in my area	❍	❍	❍	❍	❍	❍
Fiscal policies are in place in my area to support and sustain high-fidelity wraparound (family centered practice)	❍	❍	❍	❍	❍	❍
My community/area tracks outcomes and adherence to high-fidelity wraparound (family centered practice)	❍	❍	❍	❍	❍	❍

Please tell us the extent you agree that the following prevention components exist in your community/area:

Q31:
There is a strong effort in my community/area to redeploy funds from higher cost to lower cost services

- ❍ Strongly Disagree
- ❍ Disagree
- ❍ Neither Agree nor Disagree
- ❍ Agree
- ❍ Strongly Agree
- ❍ I don't know

Q32:
There is a strong effort in my community/area to focus on prevention services

- ❍ Strongly Disagree
- ❍ Disagree
- ❍ Neither Agree nor Disagree
- ❍ Agree
- ❍ Strongly Agree
- ❍ I don't know

Q33:
There is a strong effort in my community/area to focus on early intervention services

- ❍ Strongly Disagree
- ❍ Disagree
- ❍ Neither Agree nor Disagree
- ❍ Agree
- ❍ Strongly Agree
- ❍ I don't know

You are almost done

Now we are going to ask you to think about the entire State of Nebraska, not just your community or area, as you answer the next set of questions.

Q34:
There is a formal interagency State level team for joint decision making across child-serving systems

- ❍ Strongly Disagree
- ❍ Disagree
- ❍ Neither Agree nor Disagree
- ❍ Agree
- ❍ Strongly Agree
- ❍ I don't know

Q35:
There is clear accountability for making State level policy decisions for services to children & families

- ❍ Strongly Disagree
- ❍ Disagree
- ❍ Neither Agree nor Disagree
- ❍ Agree
- ❍ Strongly Agree
- ❍ I don't know

Q36:
State agencies jointly collect or analyze outcome data to improve the quality of children and family services

- ❍ Strongly Disagree
- ❍ Disagree
- ❍ Neither Agree nor Disagree
- ❍ Agree
- ❍ Strongly Agree
- ❍ I don't know

Please tell us the extent you agree that the following trauma informed care components exist at the state level in Nebraska:

Q37:
Agencies work together at the State level to plan for the needs of children and families who have experienced trauma

- ❍ Strongly Disagree
- ❍ Disagree
- ❍ Neither Agree nor Disagree
- ❍ Agree
- ❍ Strongly Agree
- ❍ I don't know

Q38:
Interagency collaboration exists at the state level to equip workers to address the needs of children and families who have experienced trauma

- ❍ Strongly Disagree
- ❍ Disagree
- ❍ Neither Agree nor Disagree
- ❍ Agree
- ❍ Strongly Agree
- ❍ I don't know

Please tell us the extent you agree that the following service and support components exist at the State level in Nebraska:

Q39:
An appropriate array of services for children and families is available statewide

- ❍ Strongly Disagree
- ❍ Disagree
- ❍ Neither Agree nor Disagree
- ❍ Agree
- ❍ Strongly Agree
- ❍ I don't know

Q40:
There is an interagency effort to ensure high quality services for children and families at the State level

- ❍ Strongly Disagree
- ❍ Disagree
- ❍ Neither Agree nor Disagree
- ❍ Agree
- ❍ Strongly Agree
- ❍ I don't know

Q41:
Coordination of care for children and families across services and systems occurs regularly at a State interagency level

- ❍ Strongly Disagree
- ❍ Disagree
- ❍ Neither Agree nor Disagree
- ❍ Agree
- ❍ Strongly Agree
- ❍ I don't know

Please tell us the extent you agree that the following youth and family partnerships exist at the State level in Nebraska:

Q42:
At the State level, families are influential partners working with agencies to decide youth/family policies

- ❍ Strongly Disagree
- ❍ Disagree
- ❍ Neither Agree nor Disagree
- ❍ Agree
- ❍ Strongly Agree
- ❍ I don't know

Q43:
At the State level, youth are influential partners working with agencies to decide youth/family policies

- ❍ Strongly Disagree
- ❍ Disagree
- ❍ Neither Agree nor Disagree
- ❍ Agree
- ❍ Strongly Agree
- ❍ I don't know

Q44:
Families have strong statewide advocacy organizations

- ❍ Strongly Disagree
- ❍ Disagree
- ❍ Neither Agree nor Disagree
- ❍ Agree
- ❍ Strongly Agree
- ❍ I don't know

Q45:
Youth have strong statewide advocacy organizations

- ❍ Strongly Disagree
- ❍ Disagree
- ❍ Neither Agree nor Disagree
- ❍ Agree
- ❍ Strongly Agree
- ❍ I don't know

Q46:
Please tell us the extent you agree that the following culturally and linguistically appropriate care components exist at the State level in Nebraska:

	Strongly Disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly Agree	I don't know
Individuals working together to improve children and family services, represent the diversity of the state	❍	❍	❍	❍	❍	❍
Agencies work together to effectively address racial/ethnic disparities in service delivery (State level)	❍	❍	❍	❍	❍	❍
Agencies work together to ensure services for children and families are culturally and linguistically appropriate (State level)	❍	❍	❍	❍	❍	❍

Please tell us the extent you agree that the following financial components exist at the State level in Nebraska:

Q47:
The State has an effective approach to coordinate funding across child serving systems

- ❍ Strongly Disagree
- ❍ Disagree
- ❍ Neither Agree nor Disagree
- ❍ Agree
- ❍ Strongly Agree
- ❍ I don't know

Q48:
The State maximizes the use of federal funds (e.g., Medicaid, federal grants, other federal entitlements) for children and family services

- ❍ Strongly Disagree
- ❍ Disagree
- ❍ Neither Agree nor Disagree
- ❍ Agree
- ❍ Strongly Agree
- ❍ I don't know

Q49:
There is a clear and feasible plan for sustaining fiscal support for children and family services in Nebraska

- ❍ Strongly Disagree
- ❍ Disagree
- ❍ Neither Agree nor Disagree
- ❍ Agree
- ❍ Strongly Agree
- ❍ I don't know

Q50:
Please tell us the extent you agree that the following workforce development components exist at a State level in Nebraska

	Strongly Disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly Agree	I don't know
Nebraska has an effective approach to ensure workers are trained in the system of care approach	❍	❍	❍	❍	❍	❍
Workers are trained to effectively provide high-fidelity wraparound (State level)	❍	❍	❍	❍	❍	❍
Workers are trained to effectively provide evidence-based treatments (State level)	❍	❍	❍	❍	❍	❍

Q 51:
Please tell us the extent you agree that the following social marketing and communication components exist at the State level in Nebraska:

	Strongly Disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly Agree	I don't know
A state-wide social marketing/strategic communication plan to inform key stakeholders about the system of care	❍	❍	❍	❍	❍	❍
Key state leaders are partners in state efforts to communicate about the system of care	❍	❍	❍	❍	❍	❍
Data and family stories are used to communicate about the system of care at the State level	❍	❍	❍	❍	❍	❍

Q52:
Please tell us the extent you agree that the following high fidelity wraparound (family centered practice) components exist at the State level in Nebraska:

	Strongly Disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly Agree	I don't know
Agencies are working in partnership to support high-fidelity wraparound (family centered practice) at the State level	❍	❍	❍	❍	❍	❍
Fiscal policies are in place at the state level to support and sustain high-fidelity wraparound (family centered practice)	❍	❍	❍	❍	❍	❍
The State tracks outcomes and adherence to high-fidelity wraparound (family centered practice)	❍	❍	❍	❍	❍	❍

Please tell us the extent you agree that the following prevention components exist at the State level in Nebraska:

Q53:
There is a strong state effort to redeploy funds from higher cost to lower cost services

- ❍ Strongly Disagree
- ❍ Disagree
- ❍ Neither Agree nor Disagree
- ❍ Agree
- ❍ Strongly Agree
- ❍ I don't know

Q54:
There is a strong state effort to focus on prevention services

- ❍ Strongly Disagree
- ❍ Disagree
- ❍ Neither Agree nor Disagree
- ❍ Agree
- ❍ Strongly Agree
- ❍ I don't know

Q55:
There is a strong state effort to focus on early intervention services

- ❍ Strongly Disagree
- ❍ Disagree
- ❍ Neither Agree nor Disagree
- ❍ Agree
- ❍ Strongly Agree
- ❍ I don't know

Q56: For **your community,** please rate up to 6 System of Care (SOC) components for each group by putting the number 1 next to the most important, 2 to the second most important etc. Please do not rank more than six (6) items for each group.

Community - current strengths These are components that currently exist in your community/area that are important in meeting the needs of children and families	**Community - current greatest needs** These are components that don't exist but are most needed to better meet the needs of children and families.
_____ Formal interagency team to make decisions about SOC	_____ Formal interagency team to make decisions about SOC
_____ Clear accountability for SOC policy decisions	_____ Clear accountability for SOC policy decisions
_____ Collaboration to improve trauma informed care	_____ Collaboration to improve trauma informed care
_____ Broad array of effective services	_____ Broad array of effective services
_____ Coordination of care across systems	_____ Coordination of care across systems
_____ Accessible services	_____ Accessible services
_____ Families partnering on policy decisions	_____ Families partnering on policy decisions
_____ Youth partnering on policy decisions	_____ Youth partnering on policy decisions
_____ Strong family advocacy groups	_____ Strong family advocacy groups
_____ Strong youth advocacy groups	_____ Strong youth advocacy groups
_____ Reduce disparities in service delivery	_____ Reduce disparities in service delivery
_____ Culturally & linguistically appropriate services	_____ Culturally & linguistically appropriate services
_____ Coordinated/sustainable funding across systems	_____ Coordinated/sustainable funding across systems
_____ Maximize federal funding	_____ Maximize federal funding
_____ Highly trained work force	_____ Highly trained work force
_____ Training in system of care approach	_____ Training in system of care approach
_____ Social marketing/strategic communication about SOC	_____ Social marketing/strategic communication about SOC
_____ Agencies partnering to improve high fidelity wraparound	_____ Agencies partnering to improve high fidelity wraparound
_____ Outcome measurement & quality improvement systems	_____ Outcome measurement & quality improvement systems
_____ Focus on prevention	_____ Focus on prevention
_____ Focus on early intervention	_____ Focus on early intervention

Q 57: For the **State of Nebraska,** please rate up to 6 System of Care (SOC) components for each group by putting the number 1 next to the most important, 2 to the second most important etc. Please do not rank more than six (6) items for each group.

.

State of Nebraska - current strengths These are components that currently exist in your community/area that are important in meeting the needs of children and families	**State of Nebraska - current greatest needs** These are components that don't exist but are most needed to better meet the needs of children and families.
_____ Formal interagency team to make decisions about SOC	_____ Formal interagency team to make decisions about SOC
_____ Clear accountability for SOC policy decisions	_____ Clear accountability for SOC policy decisions
_____ Collaboration to improve trauma informed care	_____ Collaboration to improve trauma informed care
_____ Broad array of effective services	_____ Broad array of effective services
_____ Coordination of care across systems	_____ Coordination of care across systems
_____ Accessible services	_____ Accessible services
_____ Families partnering on policy decisions	_____ Families partnering on policy decisions
_____ Youth partnering on policy decisions	_____ Youth partnering on policy decisions
_____ Strong family advocacy groups	_____ Strong family advocacy groups
_____ Strong youth advocacy groups	_____ Strong youth advocacy groups
_____ Reduce disparities in service delivery	_____ Reduce disparities in service delivery
_____ Culturally & linguistically appropriate services	_____ Culturally & linguistically appropriate services
_____ Coordinated/sustainable funding across systems	_____ Coordinated/sustainable funding across systems
_____ Maximize federal funding	_____ Maximize federal funding
_____ Highly trained work force	_____ Highly trained work force
_____ Training in system of care approach	_____ Training in system of care approach
_____ Social marketing/strategic communication about SOC	_____ Social marketing/strategic communication about SOC
_____ Agencies partnering to improve high fidelity wraparound	_____ Agencies partnering to improve high fidelity wraparound
_____ Outcome measurement & quality improvement systems	_____ Outcome measurement & quality improvement systems
_____ Focus on prevention	_____ Focus on prevention
_____ Focus on early intervention	_____ Focus on early intervention

Q 58:
What other recommendations do you have to develop and improve systems of care and high-fidelity wraparound (family centered practice) for children, youth and families across Nebraska communities?

Thank you for taking the time to complete this survey

If you have questions or concerns about a child or youth in Nebraska you can contact the Nebraska Family Helpline 1-888-866-8660

Please return this survey to your Regional Behavioral Health Office or mail it to:

University of Nebraska Public Policy Center
PO Box 880228
Lincoln, NE 68588-0228

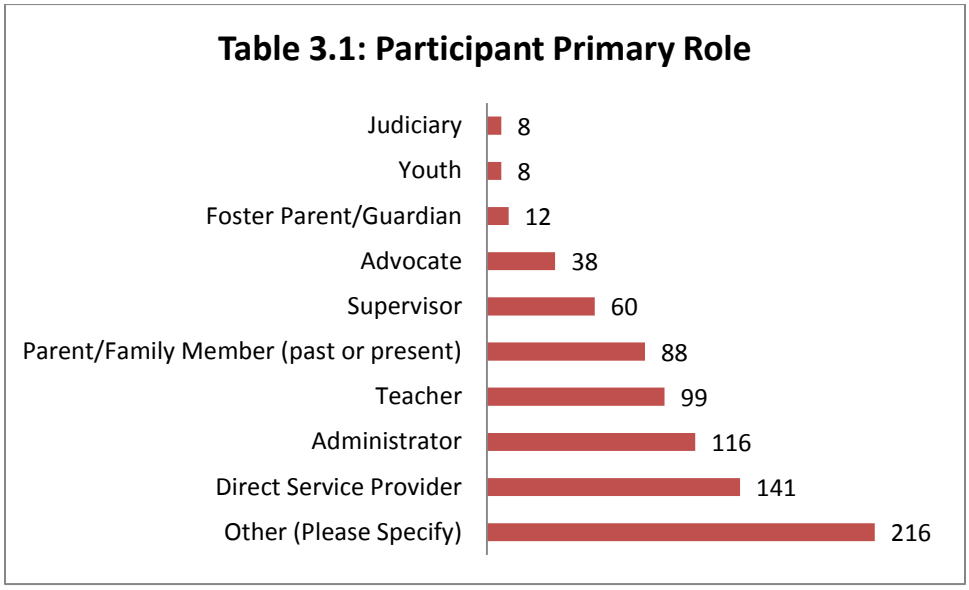
APPENDIX 2: FOCUS GROUP QUESTIONS

System of Care Focus Group/Interview Questions:

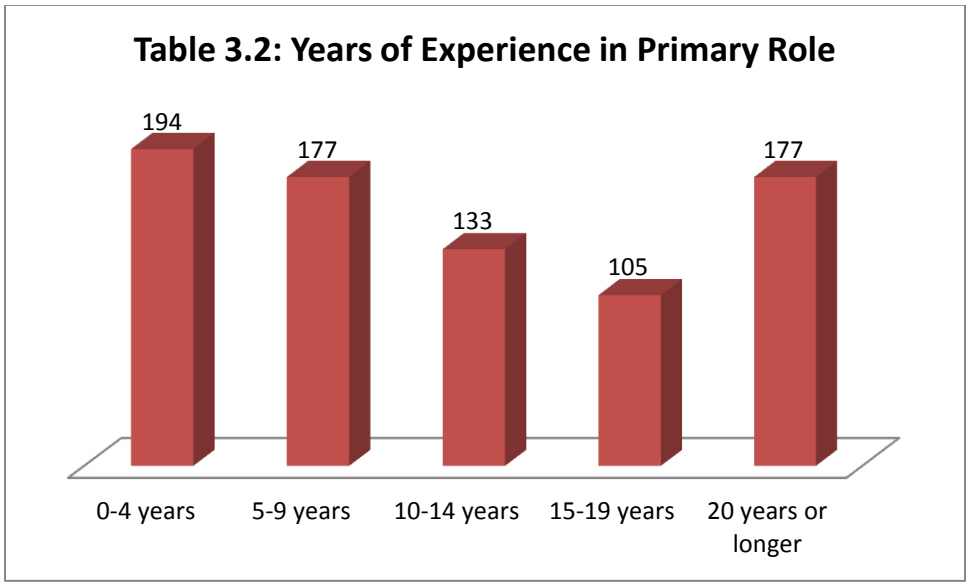
1. Identify region, role, systems involvement, positions, race/ethnicity of participants
2. How are child or youth/family systems working together in your community developing systems of care (see definition)?
    a. What does interagency collaboration look like here?
    b. What elements are in place?
    c. What are the strengths of your community in this area?
    d. What are the needs?
    e. What are the barriers?
    f. What exists that hasn't been helpful?
    g. What financing strategies support systems of care (optional depending on group)?
    h. What social marketing efforts are there to promote systems of care?
3. How are systems and organizations developing high-fidelity wraparound (see definition)?
    a. Strengths
    b. Gaps
4. How are families and youth involved in these efforts?
    a. Strengths
    b. Gaps
5. What are the service strengths and gaps in your community?
    a. Array of evidence based/effective services?
    b. Trauma informed care?
    c. Prevention?
    d. Training/workforce development?
    e. Culturally and linguistically appropriate services?
6. What else could improve the State/community's approach to improving the lives of youth and families?

APPENDIX 3: PARTICIPANT CHARACTERISTICS

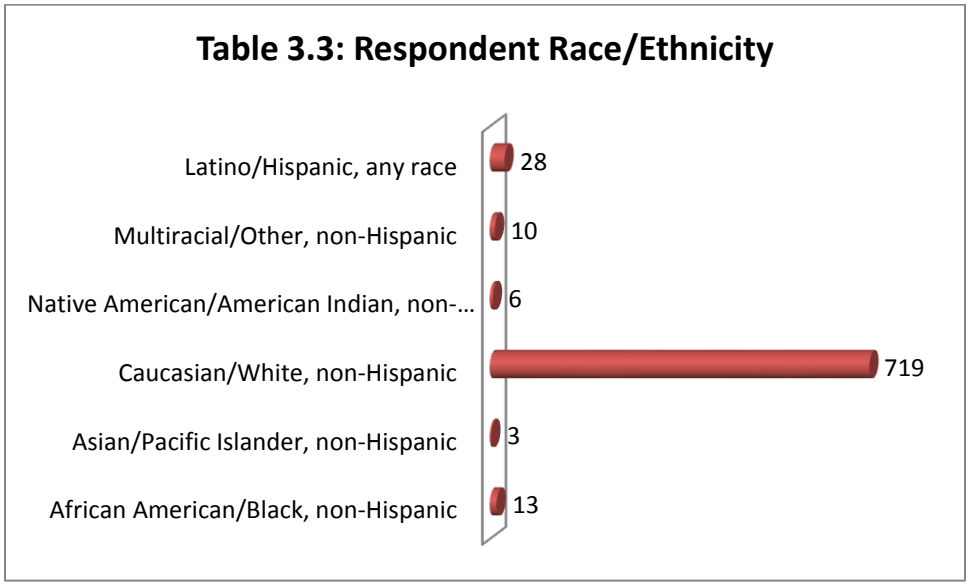
Participants identified themselves in a variety of roles. The most common were direct service provider and other roles (see Figure 3.1). Most of the "other" descriptions indicated they were likely service providers: counselor, school counselor, guidance counselor, nurse, and school nurse were the most common.



Participant had a range of experience (see Figure 3.2)



Participants were primarily white, non-Hispanic (see Figure 3.3)

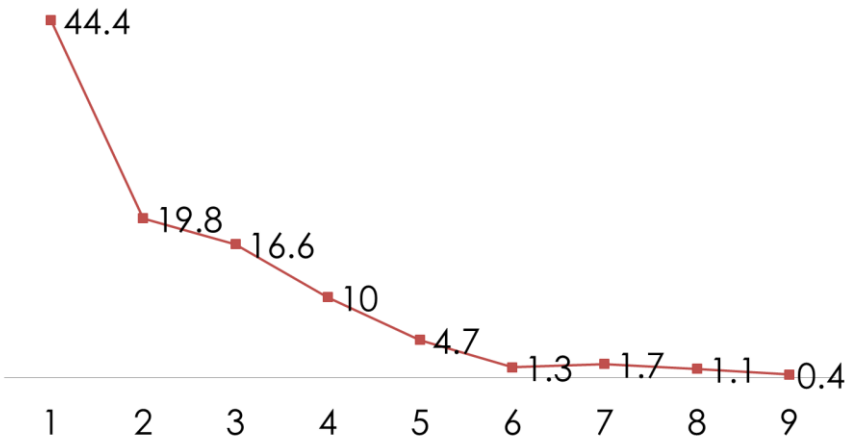


Participants were involved in a variety of youth-serving systems. Table 3.1 shows the systems in which participants were involved and Figure 3.4 shows the number of systems of in which participants were involved. "Other" includes legislative aides, mentoring programs, faith-based organizations, homeless prevention programs, mediation, services for the visually impaired, and violence prevention programs.

System	Family	Youth	Stakeholder	Respondent (Duplicative)
Child Welfare	15.1%	0.4%	84.5%	238
Developmental Dis.	20.7%		79.3%	140
Early Childhood	13.2%		86.8%	144
Education	8.5%		91.5%	365
Healthcare	23.8%	1.0%	75.2%	105
Mental Health	18.4%	2.3%	79.3%	305
Substance Abuse	10.2%	1.9%	88.0%	108
Vocational Rehabilitation	11.4%	2.3%	86.4%	44

Juvenile Justice	14.1%	1.4%	84.5%	213
Other	14.5%	1.8%	83.6%	55

Table 3.4: Percent of Participants Involved by Number of Systems



APPENDIX 4: RATINGS OF STATE/COMMUNITY STRENGTHS/NEEDS

Table 4.1: Rating of Community SOC Strategies ("1" indicating strongly disagree to"5" strongly agree that component exists)

SOC Component	Core Strategy	Rating
There is a strong effort in my community/area to redeploy funds from higher cost to lower cost services	Prevention	3.92
There is an appropriate array of services for children and families in my community or area	Services	3.58
Workers are trained to effectively respect and work with children and families in my community	Workforce	3.22
There is a strong effort in my community/area to focus on early intervention services	Prevention	2.92
Services in my community/area are high quality	Services	2.89
Agencies work together to ensure services for children and families are culturally and linguistically appropriate	Culture	2.89
Workers are trained to effectively provide evidence-based treatments	Workforce	2.87
People are working in partnership to support high-fidelity wraparound (family centered practice) in my area	Wraparound	2.87
My community/area has a formal interagency community team for joint policy decision making across child-serving systems	Policy	2.84
Workers are trained to effectively provide high-fidelity wraparound	Workforce	2.82
Agencies work together to effectively address racial/ethnic disparities in service delivery	Culture	2.79
Individuals working together to improve children and family services, represent the diversity of my community or area	Culture	2.76
Service providers are well trained in addressing the needs of children and families who have experienced trauma in my community/area	Trauma	2.74
Services are accessible in my community/area	Services	2.68
There is a strong effort in my community/area to focus on prevention services	Prevention	2.67
Community/area agencies jointly collect or analyze outcome data to improve the quality of children and family services	Policy	2.65
Families have strong advocacy organizations in my community/area	Youth/ Family	2.63
My community/area tracks outcomes and adherence to high-fidelity wraparound (family centered practice)	Wraparound	2.62
In my community/area, families are influential partners working with agencies to decide youth/family policies	Youth/ Family	2.60
Data and family stories are used in communications about the system of care	Communication	2.55
Youth have strong advocacy organizations in my community/area	Youth/ Family	2.54
Key community leaders are partners in efforts to communicate about the system of care	Communication	2.54
Youth and families are able to direct their own care by choosing services and supports that meet their needs in my community/area	Youth/ Family	2.53
There is strong collaboration across agencies to plan for the needs of children and families who have experienced trauma in my community/area	Trauma	2.52

SOC Component	Core Strategy	Rating
There is clear accountability for making community/area policy decisions for services to children & families	Policy	2.47
Coordination of care across services and systems occurs regularly in my community or area	Services	2.46
Agencies work together to effectively coordinate funding across child serving systems in my community/area	Finance	2.44
In my community/area, flexible funding can be used to address the unique needs of each child and family	Finance	2.42
Fiscal policies are in place in my area to support and sustain high-fidelity wraparound (family centered practice)	Wrap around	2.40
In my community/area, youth are influential partners working with agencies to decide youth/family policies	Youth/ Family	2.30
There is a local social marketing/strategic communication plan to inform people about the system of care	Communication	2.25
There is a clear and feasible plan for sustaining fiscal support for children and family services in my community/area	Finance	2.22

Table 4.2: Rating of State SOC Strategies ("1" indicating strongly disagree to"5" strongly agree that component exists)

SOC Component	Core Strategy	Rating
There is a strong state effort to redeploy funds from higher cost to lower cost services	Prevention	2.88
There is a formal interagency State level team for joint decision making across child-serving systems	Policy	2.79
Agencies work together to ensure services for children and families are culturally and linguistically appropriate (state level)	Culture	2.73
Individuals working together to improve children and family services, represent the diversity of the state	Culture	2.68
Agencies work together to effectively address racial/ethnic disparities in service delivery	Culture	2.68
State agencies jointly collect or analyze outcome data to improve the quality of children and family services	Policy	2.66
There is a strong state effort to focus on early intervention services	Prevention	2.64
Families have strong statewide advocacy organizations	Youth/ Family	2.6
Workers are trained to effectively provide evidence-based treatments (state level)	Work force	2.59
Agencies are working in partnership to support high-fidelity wraparound (family centered practice) at the state level	Wrap around	2.59
The state tracks outcomes and adherence to high-fidelity wraparound (family centered practice)	Wrap around	2.58
Nebraska has an effective approach to ensure workers are trained in the system of care approach	Workforce	2.55
Workers are trained to effectively provide high-fidelity wraparound (state level)	Workforce	2.55
Agencies work together at the state level to plan for the needs of children and families who have experienced trauma	Trauma	2.50
Key state leaders are partners in state efforts to communicate about the system of care	Communication	2.50
Data and family stories are used to communicate about the system of care at the state level	Communication	2.50
There is a strong state effort to focus on prevention services	Prevention	2.50
There is an interagency effort to ensure high quality services for children and families at the state level	Service	2.44
Youth have strong statewide advocacy organizations	Youth/ Family	2.42
Interagency collaboration exists at the state level to equip workers to address the needs of children and families who have experienced trauma	Trauma	2.40
A state-wide social marketing/strategic communication plan to inform key stakeholders about the system of care	Communication	2.36
At the state level, families are influential partners working with agencies to decide youth/family policies	Youth/ Family	2.31
Fiscal policies are in place at the state level to support and sustain high-fidelity wraparound (family centered practice)	Wrap around	2.30
There is clear accountability for making State level policy decisions for services to children & families	Policy	2.27
Coordination of care for children and families across services and systems occurs regularly at a state interagency level	Service	2.26
At the state level, youth are influential partners working with agencies to decide youth/family policies	Youth/ Family	2.2
The State maximizes the use of federal funds (e.g., Medicaid, federal grants, other federal	Finance	2.14

SOC Component	Core Strategy	Rating
entitlements) for children and family services		
An appropriate array of services for children and families is available statewide	Service	2.02
There is a clear and feasible plan for sustaining fiscal support for children and family services in Nebraska	Finance	2.02
The State has an effective approach to coordinate funding across child serving systems	Finance	2.00

Table 4.3: Rank Ordering of Community Strengths and Needs (lower ranking indicates greater strength and greater need)

	Community Strengths		Community Needs	
1	Focus on early intervention	5.45	Accessible services	5.03
2	Focus on prevention	5.86	Broad array of effective services	5.34
3	Broad array of effective services	5.97	Focus on prevention	5.47
4	Accessible services	5.97	Focus on early intervention	5.73
5	Strong family advocacy groups	5.97	Coordination of care across systems	5.75
6	Highly trained work force	6.01	Collaboration to improve trauma informed care	5.96
7	Collaboration to improve trauma informed care	6.11	Reduce disparities in service delivery	5.96
8	Culturally & linguistically appropriate services	6.13	Coordinated/sustainable funding across systems	5.99
9	Formal interagency team to make decisions about SOC	6.17	Highly trained work force	6.03
10	Agencies partnering to improve high fidelity wraparound	6.17	Maximize federal funding	6.11
11	Training in system of care approach	6.32	Culturally & linguistically appropriate services	6.23
12	Strong youth advocacy groups	6.33	Clear accountability for SOC policy decisions	6.26
13	Coordination of care across systems	6.35	Agencies partnering to improve high fidelity wraparound	6.30
14	Outcome measurement & quality improvement systems	6.48	Families partnering on policy decisions	6.34
15	Maximize federal funding	6.67	Youth partnering on policy decisions	6.46
16	Families partnering on policy decisions	6.69	Strong family advocacy groups	6.47
17	Youth partnering on policy decisions	6.69	Formal interagency team to make decisions about SOC	6.48
18	Reduce disparities in service delivery	6.69	Strong youth advocacy groups	6.50
19	Coordinated/sustainable funding across systems	6.80	Outcome measurement & quality improvement systems	6.54
20	Clear accountability for SOC policy decisions	6.83	Training in system of care approach	6.56
21	Social marketing/strategic communication about SOC	6.87	Social marketing/strategic communication about SOC	6.78

Range from 1= greatest strength/need to 7= Not ranked

Table 4.4: Rank Ordering of State Strengths and Needs (lower ranking indicates greater strength and greater need)

	State Strength		State Need	
1	Focus on early intervention	5.64	Accessible services	5.20
2	Strong family advocacy groups	5.88	Maximize federal funding	5.59
3	Focus on prevention	5.93	Broad array of effective services	5.69
4	Collaboration to improve trauma informed care	6.01	Coordination of care across systems	5.69
5	Broad array of effective services	6.03	Reduce disparities in service delivery	5.73
6	Culturally & linguistically appropriate services	6.14	Focus on prevention	5.73
7	Highly trained work force	6.15	Focus on early intervention	5.8
8	Outcome measurement & quality improvement systems	6.22	Coordinated/sustainable funding across systems	5.85
9	Formal interagency team to make decisions about SOC	6.26	Clear accountability for SOC policy decisions	5.95
10	Training in system of care approach	6.27	Highly trained work force	5.96
11	Coordination of care across systems	6.39	Agencies partnering to improve high fidelity wraparound	6.23
12	Accessible services	6.40	Collaboration to improve trauma informed care	6.24
13	Agencies partnering to improve high fidelity wraparound	6.45	Families partnering on policy decisions	6.41
14	Maximize federal funding	6.50	Outcome measurement & quality improvement systems	6.48
15	Families partnering on policy decisions	6.54	Strong family advocacy groups	6.50
16	Strong youth advocacy groups	6.59	Culturally & linguistically appropriate services	6.50
17	Clear accountability for SOC policy decisions	6.63	Training in system of care approach	6.55
18	Reduce disparities in service delivery	6.73	Strong youth advocacy groups	6.59
19	Youth partnering on policy decisions	6.76	Youth partnering on policy decisions	6.60
20	Social marketing/strategic communication about SOC	6.81	Formal interagency team to make decisions about SOC	6.65
21	Coordinated/sustainable funding across systems	6.82	Social marketing/strategic communication about SOC	6.71

Range from 1= greatest strength/need to 7= Not ranked

APPENDIX 5: RATINGS/RANKINGS ANALYSIS BY AREA OF THE STATE

Community System of Care Components	Region of the State						
	1	2	3	4	5	6	State
There is clear accountability for making community/area policy decisions for services to children & families	2.64	2.63	2.43	2.82*	2.45	2.31	2.36
My community/area has a formal interagency community team for joint policy decision making across child-serving systems	2.91	3.31	2.83	3.12	2.82	2.67	2.76
Community/area agencies jointly collect or analyze outcome data to improve the quality of children and family services	2.74	3.00*	2.49	3.00*	2.68	2.55	2.45
There is strong collaboration across agencies to plan for the needs of children and families who have experienced trauma in my community/area.	2.85	2.84	2.45	2.69	2.41	2.53	2.36
Service providers are well trained in addressing the needs of children and families who have experienced trauma in my community/area.	3.06*	2.92	2.79	3.07*	2.60	2.69	2.31
There is an appropriate array of services for children and families in my community or area	3.73	3.41	3.67	3.52	3.45	3.61	3.72^
Coordination of care across services and systems occurs regularly in my community or area	2.50	3.16*	2.52	2.76	2.37	2.35	2.11
Services in my community/area are high quality	3.00	2.85	2.72	3.00	2.93	2.98	2.63
Services are accessible in my community/area	2.66	2.69	2.67	2.76	2.76	2.63	2.55
Youth and families are able to direct their own care by choosing services and supports that meet their needs in my community/area	2.61	2.88*	2.46	2.84*	2.50	2.40	2.50
In my community/area, families are influential partners working with agencies to decide youth/family policies	2.43	2.81	2.69	2.87	2.55	2.55	2.35
In my community/area, youth are influential partners working with agencies to decide youth/family policies	2.52*	2.54#	2.38	2.54*	2.21	2.17	2.10
Families have strong advocacy organizations in my community/area	2.54	2.85	2.59	2.58	2.71	2.61	2.58
Youth have strong advocacy organizations in my community/area	2.73	2.85	2.54	2.75	2.53	2.38	2.31
Individuals working together to improve children and family services, represent the diversity of my community or area	3.27*	3.05	2.82	2.94	2.59	2.67	2.71
Agencies work together to effectively address racial/ethnic disparities in service delivery	2.98	3.23	2.82	2.91	2.75	2.65	2.76

Community System of Care Components	Region of the State						
	1	2	3	4	5	6	State
Agencies work together to ensure services for children and families are culturally and linguistically appropriate	3.16	3.00	2.89	3.05	2.81	2.82	2.85
Agencies work together to effectively coordinate funding across child serving systems in my community/area	2.83*	2.92*	2.53*	2.71*	2.23	2.27	2.39
There is a clear and feasible plan for sustaining fiscal support for children and family services in my community/area	2.49	2.77*	2.23#	2.70*	2.09#	2.07#	1.86#
In my community/area, flexible funding can be used to address the unique needs of each child and family	2.62*	2.7*	2.57*	2.66*	2.34	2.24	2.29
Workers are trained to effectively respect and work with children and families in my community	3.18	3.54^	3.27	3.32	3.24	3.16	2.95
Workers are trained to effectively provide high-fidelity wraparound	2.79	3.52*	2.86	3.05	2.73	2.78	2.38
Workers are trained to effectively provide evidence-based treatments	2.97	3.52*	2.88	2.98	2.83	2.81	2.50
There is a local social marketing/strategic communication plan to inform people about the system of care	2.51*	2.61*	2.31	2.40#	2.16	2.14	1.94
Key community leaders are partners in efforts to communicate about the system of care	2.76	2.87	2.48	2.65	2.48	2.56	2.31
Data and family stories are used in communications about the system of care	2.67	2.83	2.54	2.67	2.53	2.54	2.29
People are working in partnership to support high-fidelity wraparound (family centered practice) in my area	2.93	3.35	2.89	3.12	2.73	2.87	2.58
Fiscal policies are in place in my area to support and sustain high-fidelity wraparound (family centered practice)	2.31*#	3.19*	2.53	2.70	2.27	2.26	2.14
My community/area tracks outcomes and adherence to high-fidelity wraparound (family centered practice)	2.74	3.19*	2.71	2.80	2.50	2.63	2.09
There is a strong effort in my community/area to redeploy funds from higher cost to lower cost services	4.09^	3.32	4.25*^	4.03^	4.07^	3.71^	3.17
There is a strong effort in my community/area to focus on prevention services	3.02*	3.08*	2.63	3.19*	2.57	2.46	2.53
There is a strong effort in my community/area to focus on early intervention services	3.19*	3.28*	2.86	3.17*	3.02*	2.74	2.48

Yellow* indicates significantly higher ratings than most or all other geographic areas for the component (rows) Green^ indicates highest rated item within each geographic area (column); blue# indicates lowest rated item within geographic area (column). For these questions:
1 = Strongly Disagree; 2 = Disagree; 3 = Neither Agree nor Disagree; 4 = Agree; and 5 = Strongly Agree

State System of Care Components	Region of the State						
	1	2	3	4	5	6	State
There is a formal interagency State level team for joint decision making across child-serving systems	2.77	3.18	2.82	2.98	2.72	2.73	2.63^
There is clear accountability for making State level policy decisions for services to children & families	2.29	2.64*	2.34	2.65*	2.14	2.11	2.30
State agencies jointly collect or analyze outcome data to improve the quality of children and family services	2.82	2.91	2.58	3.04	2.63	2.56	2.43
Agencies work together at the state level to plan for the needs of children and families who have experienced trauma	2.72	2.77	2.51	3.04*	2.42	2.30	2.36
Interagency collaboration exists at the state level to equip workers to address the needs of children and families who have experienced trauma	2.61*	2.91*	2.55*	2.79*	2.27	2.18	2.16
An appropriate array of services for children and families is available statewide	2.07	2.32#	2.13	2.46*#	1.91	1.80#	2.08
There is an interagency effort to ensure high quality services for children and families at the state level	2.55	2.95*	2.38	2.98*	2.35	2.26	2.37
Coordination of care for children and families across services and systems occurs regularly at a state interagency level	2.43	3.00*	2.24	2.80*	2.17	2.03	2.05
At the state level, families are influential partners working with agencies to decide youth/family policies	2.20	2.55	2.48	2.77*	2.26	2.10	2.16
At the state level, youth are influential partners working with agencies to decide youth/family policies	2.28	2.70*	2.37*	2.67*	2.11	1.95	2.00
Families have strong statewide advocacy organizations	2.78	3.45*^	2.65	2.74	2.52	2.42	2.58
Youth have strong statewide advocacy organizations	2.69	3.05*	2.46	2.64	2.44	2.2	2.09
Individuals working together to improve children and family services, represent the diversity of the state	2.85	3.21*	2.88*^	3.05*	2.56	2.47	2.42
Agencies work together to effectively address racial/ethnic disparities in service delivery (state level)	2.88	3.37*	2.80	3.02*	2.53	2.53	2.36
Agencies work together to ensure services for children and families are culturally and linguistically appropriate (state level)	2.91	3.32*	2.87	3.00*	2.61	2.58	2.42
The State has an effective approach to coordinate funding across child serving systems	1.89#	2.52*	2.01#	2.68*	1.93	1.81	1.84
The State maximizes the use of federal funds (e.g., Medicaid, federal grants, other federal entitlements) for children and family services	2.06	2.86*	2.24	2.89*	2.01	1.89	1.94
There is a clear and feasible plan for sustaining fiscal support for children and family services in Nebraska	2.03	2.7*	2.09	2.69*	1.88#	1.81	1.80#
Nebraska has an effective approach to ensure workers are trained in the system of care approach	2.47	3.3*	2.67	3.07*	2.37	2.45	2.14

State System of Care Components	Region of the State						
	1	2	3	4	5	6	State
Workers are trained to effectively provide high-fidelity wraparound (state level)	2.36	3.35*	2.70	3.29*	2.32	2.43	2.15
Workers are trained to effectively provide evidence-based treatments (state level)	2.59	3.35*	2.63	3.24*	2.42	2.49	2.18
A state-wide social marketing/strategic communication plan to inform key stakeholders about the system of care	2.69*	2.68*	2.49*	2.61*	2.28	2.12	2.26
Key state leaders are partners in state efforts to communicate about the system of care	2.58	2.94*	2.48	3.02*	2.33	2.44	2.24
Data and family stories are used to communicate about the system of care at the state level	2.26	3.00	2.51	2.73	2.44	2.47	2.34
Agencies are working in partnership to support high-fidelity wraparound (family centered practice) at the state level	2.69	2.85	2.67	3.09*	2.41	2.56	2.24
Fiscal policies are in place at the state level to support and sustain high-fidelity wraparound (family centered practice)	2.26	2.80*	2.51	2.95*	2.09	2.11	2.00
The state tracks outcomes and adherence to high-fidelity wraparound (family centered practice)	2.58	3.15*	2.82	3.16*	2.45	2.33	2.23
There is a strong state effort to redeploy funds from higher cost to lower cost services	2.94	3.10	2.79	3.41*^	2.93^	2.79^	2.43
There is a strong state effort to focus on prevention services	2.85*	3.00*	2.57	2.96*	2.43	2.24	2.19
There is a strong state effort to focus on early intervention services	3.05^	3.05	2.64	3.12*	2.73	2.30	2.19

Yellow* indicates significantly higher ratings than most or all other geographic areas for the component (rows)
Green^ indicates highest rated item within each geographic area (column); blue# indicates lowest rated item within geographic area (column). For these questions:
1 = Strongly Disagree; 2 = Disagree; 3 = Neither Agree nor Disagree; 4 = Agree; and 5 = Strongly Agree

Community Strengths	Region of the State						
	1	2	3	4	5	6	State
Formal interagency team to make decisions about SOC	5.29^	5.06^	6.23	6.71	6.31	6.31	5.89
Clear accountability for SOC policy decisions	6.61	6.69	6.70	6.86	6.94#	6.89#	6.82
Collaboration to improve trauma informed care	5.36	5.44	6.25	6.60	5.84	6.26	6.61
Broad array of effective services	6.07	6.81	6.00	6.26	5.84	5.93	5.46^
Coordination of care across systems	5.71	5.00^	6.44	6.02	6.31	6.75	6.79
Accessible services	5.87	5.75	6.61	6.19	5.85	5.64^	5.89
Families partnering on policy decisions	6.39	7.00#	6.82	6.52	6.57	6.86	6.57
Youth partnering on policy decisions	6.52	7.00#	6.65	6.52	6.79	6.64	6.86
Strong family advocacy groups	6.45	6.13	6.09	5.76	5.67	6.15	5.79
Strong youth advocacy groups	6.10	5.81	6.07	6.26	6.62	6.22	7.00#
Reduce disparities in service delivery	7.00#	6.38	6.79	6.71	6.61	6.68	6.61
Culturally & linguistically appropriate services	6.36	6.44	5.55	6.10	6.31	6.26	6.14
Coordinated/sustainable funding across systems	6.65	6.94	6.80	6.69	6.93	6.69	7.00#
Maximize federal funding	6.77	7.00#	6.65	6.95#	6.72	6.60	6.11
Highly trained workforce	6.03	5.88	6.48	5.62	5.81	6.07	5.93
Training in system of care approach	6.77	6.38	6.48	6.41	6.15	6.30	5.93
Social marketing/strategic communication about SOC	7.00#	6.88	6.92#	6.86	6.88	6.75	7.00#
Agencies partnering to improve high-fidelity wraparound	5.81	5.81	5.90	5.91	6.50	6.23	6.57
Outcome measurement & quality improvement systems	6.48	6.38	6.75	6.19	6.60	6.32	6.39
Focus on prevention	5.39	5.56	5.72	4.91^	6.05	6.20	6.43
Focus on early intervention	5.74	5.25	5.30^	4.98	5.46^	5.66	5.54

Green^ indicates greatest strength by geographic area; blue# indicates least strength by geographic area

Scores range from 1 to 7 with 1 indicating the highest ranked and 7 indicating the component was not ranked; hence lower numbers indicate higher rankings.

- There is a significant difference across Regions in the ranking of community strengths.
- Regions 1 and 2 respondents consider "Formal interagency team to make decisions about SOC" (#1) to be the greatest strengths in their community, much more so than did other areas.
- For Region 3 and Region 5 respondents, "Focus on early intervention" (#21) is the greatest strength; other regions and state respondents also gave this item a fairly high ranking.
- Region 4 respondents think "Focus on prevention" (#20) is a strength in their community, more than do other areas.
- Region 6 respondents think "Accessible services" (#6) is their community's greatest strength.
- Statewide respondents consider "Broad array of effective services" (#4) to be the greatest strength, more than respondents in specific Regions.

Community Needs	Region of the State						
	1	2	3	4	5	6	State
Formal interagency team to make decisions about SOC	6.37	6.71	6.66	6.38	6.35	6.59	6.17
Clear accountability for SOC policy decisions	6.23	5.88	6.15	6.64	6.26	6.22	6.34
Collaboration to improve trauma informed care	6.20	4.88	6.22	6.02	5.70	6.14	5.66
Broad array of effective services	4.51^	4.47	5.08	5.28	5.43	5.79	5.46
Coordination of care across systems	5.63	6.59	5.76	5.96	5.61	5.69	5.80
Accessible services	5.06	4.00^	4.43^	5.08^	5.41	5.23^	5.14^
Families partnering on policy decisions	6.31	6.00	6.65	6.26	6.39	6.18	6.23
Youth partnering on policy decisions	6.54	5.94	6.67	6.00	6.52	6.53	6.29
Strong family advocacy groups	6.60	6.53	6.34	6.24	6.60	6.55	6.31
Strong youth advocacy groups	6.83#	6.35	6.38	5.88	6.56	6.71	6.49
Reduce disparities in service delivery	5.74	5.88	5.87	6.44	5.75	5.93	6.54
Culturally & linguistically appropriate services	6.23	5.88	6.18	6.00	6.30	6.21	6.66
Coordinated/sustainable funding across systems	5.86	6.29	6.18	5.92	6.14	5.67	6.20
Maximize federal funding	5.97	6.65	6.30	6.02	6.21	5.87	6.14
Highly trained workforce	6.26	6.41	6.21	6.28	5.95	5.88	5.63
Training in system of care approach	6.37	6.82#	6.48	6.72#	6.66	6.53	6.40
Social marketing/strategic communication about SOC	6.66	6.77	6.74#	6.24	6.95#	6.91#	6.83#
Agencies partnering to improve high-fidelity wraparound	6.06	5.94	6.28	6.12	6.30	6.49	6.31
Outcome measurement & quality improvement systems	6.51	6.77	6.70	6.60	6.60	6.49	5.94
Focus on prevention	6.49	6.18	5.45	5.86	5.19^	5.24	5.43
Focus on early intervention	5.89	6.47	5.88	5.90	5.63	5.40	6.03

Green^ indicates greatest need by geographic area; blue# indicates least need by geographic area

Scores range from 1 to 7 with 1 indicating the highest ranked and 7 indicating the component was not ranked; hence lower numbers indicate higher rankings.

- There is a significant difference across Regions in the ranking of community needs.
- Region 1 respondents think “Broad array of effective services” (#4) is the greatest need; this item was ranked similarly highly by all Regions except Region 6.
- Regions 2, 3, 4, and 6, and statewide participants ranked “Accessible services” (#6) as a big need; Region 1 and 5 respondents also ranked this among their top needs .
- Region 5 respondents think “Focus on prevention” (#20) is a need in their community; this view is shared by Region 6 respondents, but less so by other respondents (especially those in Regions 1 and 2).

State Strengths	Region of the State						
	1	2	3	4	5	6	State
Formal interagency team to make decisions about SOC	6.39	5.07^	5.79	6.49	6.59	6.21	6.67
Clear accountability for SOC policy decisions	6.48	6.43	6.71	6.54	6.59	6.73	6.71
Collaboration to improve trauma informed care	4.87^	6.50	5.63	6.11	6.13	6.27	6.43
Broad array of effective services	6.00	6.64	6.23	6.03	6.12	5.97	5.10^
Coordination of care across systems	6.39	6.21	6.50	5.80	6.38	6.77	6.00
Accessible services	6.61	6.29	6.94#	6.66	6.38	6.26	5.10^
Families partnering on policy decisions	6.52	6.71	6.54	6.49	6.28	6.77	6.57
Youth partnering on policy decisions	6.61	7.00#	6.81	6.54	6.77	6.84	6.71
Strong family advocacy groups	6.00	5.50	5.92	6.51	5.65	5.76^	6.05
Strong youth advocacy groups	6.52	6.29	6.58	6.71	6.62	6.51	6.86
Reduce disparities in service delivery	6.65	6.36	6.81	6.83#	6.84#	6.59	6.91#
Culturally & linguistically appropriate services	6.17	6.50	5.75	6.26	6.24	6.24	5.91
Coordinated/sustainable funding across systems	6.78	6.93	6.88	6.80	6.87#	6.83	6.57
Maximize federal funding	6.87#	7.00#	6.42	6.11	6.71	6.34	6.43
Highly trained workforce	6.22	6.36	6.46	5.49^	6.15	6.14	6.43
Training in system of care approach	6.17	5.71	6.54	5.83	6.41	6.49	5.71
Social marketing/strategic communication about SOC	6.83	6.79	6.73	6.83#	6.84#	6.90#	6.57
Agencies partnering to improve high-fidelity wraparound	6.13	6.00	6.31	6.23	6.63	6.59	6.76
Outcome measurement & quality improvement systems	6.44	6.21	6.56	5.86	6.44	5.81	6.38
Focus on prevention	5.39	5.29	5.90	5.51	5.82	6.31	6.76
Focus on early intervention	6.00	5.43	5.23^	5.51	5.25^	6.13	6.14

Green^ indicates greatest strength by geographic area; blue# indicates least strength by geographic area

Scores range from 1 to 7 with 1 indicating the highest ranked and 7 indicating the component was not ranked; hence lower numbers indicate higher rankings.

- There is a significant difference across Regions in the ranking of State strengths.
- Region 1 respondents think "Collaboration to improve trauma informed care" (#3) is the greatest State strength, much more than do respondents from other regions.
- Region 2 respondents think "Formal interagency team to make decisions about SOC" (#1) is the greatest State strength, more than do other respondents.
- Region 3 and 5 respondents think "Focus on early intervention" (#21) is the greatest State strength; similar average rankings were provided by Regions 2 and 4, but not by other areas.
- For Region 4 respondents, "Highly trained work force" (#15) is the greatest State strength; this view was not shared by respondents from other areas.
- Region 6 respondents did not rank items greatly different from item to item; they consider "Strong family advocacy groups" (#9) to be the State's greatest strength.
- State respondents think "Broad array of effective services" (#4) and "Accessible services" (#6) are the greatest State strengths, but other respondents did not share this view.

State Needs	Region of the State						
	1	2	3	4	5	6	State
Formal interagency team to make decisions about SOC	6.17	7.00#	6.72	6.35	6.69	6.79#	6.45
Clear accountability for SOC policy decisions	5.66	6.88	5.85	6.15	5.95	5.99	5.65
Collaboration to improve trauma informed care	6.93#	5.44	6.56	6.28	5.95	6.12	6.52
Broad array of effective services	5.93	5.00	5.76	5.75	5.32^	5.89	6.07
Coordination of care across systems	5.28	5.94	5.63	5.90	5.68	5.69	5.84
Accessible services	5.62	3.94	5.39^	5.13^	5.33^	5.06^	5.13^
Families partnering on policy decisions	6.21	6.25	6.64	6.43	6.56	6.27	6.07
Youth partnering on policy decisions	6.38	6.56	6.78^	6.43	6.75	6.55	6.29
Strong family advocacy groups	6.52	6.69	6.46	6.10	6.63	6.43	6.87
Strong youth advocacy groups	6.17	6.56	6.60	6.08	6.86#	6.60	6.77
Reduce disparities in service delivery	5.35	5.94	5.74	5.53	5.66	5.92	5.81
Culturally & linguistically appropriate services	6.69	6.00	6.30	6.18	6.66	6.55	6.84
Coordinated/sustainable funding across systems	4.48^	6.69	6.08	6.15	5.78	5.85	5.94
Maximize federal funding	5.28	4.69^	5.76	6.15	5.42	5.52	5.97
Highly trained workforce	6.72	6.25	5.89	6.75#	5.73	5.89	5.19
Training in system of care approach	6.83	6.69	6.36	6.50	6.58	6.62	6.45
Social marketing/strategic communication about SOC	6.76	6.50	6.63	6.18	6.86#	6.79#	6.94
Agencies partnering to improve high-fidelity wraparound	5.79	6.31	5.89	6.15	6.35	6.48	6.26
Outcome measurement & quality improvement systems	6.00	7.00#	6.41	6.63	6.51	6.60	6.13
Focus on prevention	6.52	5.88	5.80	6.00	5.62	5.58	5.26
Focus on early intervention	6.17	5.88	5.60	6.15	6.09	5.59	5.32

Green^ indicates greatest need by geographic area; blue# indicates least need by geographic area

Scores range from 1 to 7 with 1 indicating the highest ranked and 7 indicating the component was not ranked; hence lower numbers indicate higher rankings.

- There is a significant difference across Regions in the ranking of State needs.
- All statewide and region respondents except those in Region 1 rank “Accessible service” (#6) as the among the greatest State needs.
- Region 5 respondents also think “Broad array of effective services” (#4) is a need, Region 2 respondents think “Maximize federal funding” (#14) is a need, and statewide respondents think “Highly trained work force” (#15) is a need.
- Region 1 respondents think “Coordinated/sustainable funding across systems” (#13) is the greatest need.

APPENDIX 6: RATINGS/RANKINGS ANALYSIS BY SERVICE SYSTEM

Because participants could indicate involvement in more than one service system, average ratings could not be compared directly between service systems. Instead, stepwise regression analysis was used to determine which service system involvement was most related to the system of care components. Once the most-related system was included, then the remaining systems were examined to see if they contributed additional explanatory power to the analysis. If they still had a significant relationship to the component after the one with the strongest relationship was included, then the subsequent systems were also included.

For most analyses, only one service system was needed to explain the ratings. For some analyses, more than one system explained the ratings better than a single system. For other analyses, there were no systems related to the ratings.

Community System of Care Components	**Service Delivery System**									
	CW	DD	EC	ED	HC	MH	SA	VR	JJ	O
There is clear accountability for making community/area policy decisions for services to children & families	2.39	2.40	2.52	2.41	2.25	2.35 #	2.48	2.33	2.42	2.53
My community/area has a formal interagency community team for joint policy decision making across child-serving systems	2.74	2.66	2.88	2.84	2.44 #	2.77	2.79	2.46	2.84	30.3
Community/area agencies jointly collect or analyze outcome data to improve the quality of children and family services	2.51	2.44 #	2.69	2.61	2.50	2.56	2.64	2.61	2.69	3.00 ^
There is strong collaboration across agencies to plan for the needs of children and families who have experienced trauma in my community/area.	2.41	2.38	2.53	2.43 #	2.32	2.39 #	2.47	2.15	2.41	2.71
Service providers are well trained in addressing the needs of children and families who have experienced trauma in my community/area.	2.59 #	2.59	2.78	2.78	2.70	2.68	2.93 ^	2.63	2.57 #	2.87
There is an appropriate array of services for children and families in my community or area	3.67	3.55	3.44	3.61	3.57	3.69	3.77	3.91	3.75 ^	3.40
Coordination of care across services and systems occurs regularly in my community or area	2.43	2.38	2.47	2.44	2.24	2.38	2.44	2.03 #	2.41	2.37
Services in my community/area are high quality	2.81 #	2.79	3.08 ^	2.80 #	2.65 #	2.90	3.02 ^	2.54	2.79	2.89
Services are accessible in my community/area	2.73	2.70	2.76	2.65	2.51	2.62	2.67	2.61	2.64	2.79
Youth and families are able to direct their own care by choosing services and supports that meet their needs in my community/area	2.49	2.53	2.54	2.55	2.54	2.45	2.52	2.18 #	2.57	2.61
In my community/area, families are influential partners working with agencies to decide youth/family policies	2.42 #	2.58	2.47	2.64	2.54	2.51	2.65	2.37	2.53	2.75
In my community/area, youth are influential partners working with agencies to decide youth/family policies	2.23	2.24	2.27	2.28	2.23	2.20 #	2.37	2.08	2.24	2.41
Families have strong advocacy organizations in my community/area	2.63	2.68	2.77	2.60	2.58	2.63	2.57	2.38.	2.70	2.77
Youth have strong advocacy organizations in my community/area	2.62	2.44	2.59	2.48	2.46	2.48	2.55	2.28	2.63	2.64
Individuals working together to improve children and family services, represent the diversity of my community or area	2.71	2.78	2.98 ^	2.70	2.83	2.74	2.77	2.49	2.63 #	3.14 ^

Community System of Care Components	Service Delivery System									
	CW	DD	EC	ED	HC	MH	SA	VR	JJ	O
Agencies work together to effectively address racial/ethnic disparities in service delivery	2.72	2.75	2.96	2.79	2.78	2.73	2.76	2.67	2.69	2.73
Agencies work together to ensure services for children and families are culturally and linguistically appropriate	2.81	2.92	3.03	2.89	2.89	2.88	2.93	2.63	2.78	2.84
Agencies work together to effectively coordinate funding across child serving systems in my community/area	2.36	2.33	2.48	2.41	2.26	2.33 #	2.45	2.21	2.38	2.35
There is a clear and feasible plan for sustaining fiscal support for children and family services in my community/area	2.13	2.02	2.30	2.17	2.04	2.10 #	2.09	2.03	2.15	2.15
In my community/area, flexible funding can be used to address the unique needs of each child and family	2.32	2.34	2.44	2.36	2.25	2.26 #	2.40	2.39	2.38	2.54
Workers are trained to effectively respect and work with children and families in my community	3.13	3.22	3.35	3.27	3.05	3.11 #	3.28	3.21	3.14	3.02
Workers are trained to effectively provide high-fidelity wraparound	2.77	2.67	2.77	2.82	2.76	2.74	2.85	2.64	2.76	2.72
Workers are trained to effectively provide evidence-based treatments	2.75 #	2.74	2.93	2.85	2.73	2.76 #	3.09 ^	2.82	2.79	2.93
There is a local social marketing/strategic communication plan to inform people about the system of care	2.16	2.28	2.26	2.17	2.30	2.23	2.14	2.09	2.16	2.54 ^
Key community leaders are partners in efforts to communicate about the system of care	2.61	2.53	2.69	2.45	2.37	2.55	2.51	2.26	2.60	2.95 ^
Data and family stories are used in communications about the system of care	2.56	2.59	2.65	2.48	2.55	2.59	2.52	2.38	2.56	2.84
People are working in partnership to support high-fidelity wraparound (family centered practice) in my area	2.77	2.73	2.86	2.78	2.72	2.84	2.77	2.44 #	2.84	3.15
Fiscal policies are in place in my area to support and sustain high-fidelity wraparound (family centered practice)	2.28 #	2.26	2.27	2.29 #	2.19	2.30	2.23	2.24	2.41	2.53
My community/area tracks outcomes and adherence to high-fidelity wraparound (family centered practice)	2.61	2.57	2.62	2.47 #	2.58	2.70	2.73	2.39	2.59	2.82
There is a strong effort in my community/area to redeploy funds from higher cost to lower cost services	3.66	3.92	4.14	4.24 ^	3.47 #	3.77	3.40	3.70	3.47 #	3.84
There is a strong effort in my community/area to focus on prevention services	2.60	2.42 #	2.75	2.63	2.54	2.55	2.63	2.50	2.64	2.98
There is a strong effort in my community/area to focus on early intervention services	2.92	2.87	3.17 ^	2.94	2.71	2.75 #	2.82	3.06	2.82	2.95

Green^ indicates system rated component higher than those not in that system; Blue# indicates system rated component lower than those not in that system.

CW = Child Welfare	MH=Mental Health
DD=Developmental Disability	SA=Substance Abuse
EC=Early Childhood	VR=Vocational Rehabilitation
ED=Education	JJ=Juvenile Justice
HC=Healthcare	O=Other (e.g., faith-based organization, childcare, legislative aid, services for visually impaired, mentoring programs, violence prevention)

State System of Care Components	Service Delivery System									
	CW	DD	EC	ED	HC	MH	SA	VR	JJ	O
There is a formal interagency State level team for joint decision making across child-serving systems							#			^
There is clear accountability for making State level policy decisions for services to children & families				#		#				^
State agencies jointly collect or analyze outcome data to improve the quality of children and family services							#			^
Agencies work together at the state level to plan for the needs of children and families who have experienced trauma										^
Interagency collaboration exists at the state level to equip workers to address the needs of children and families who have experienced trauma										^
An appropriate array of services for children and families is available statewide			^	#		#			#	
There is an interagency effort to ensure high quality services for children and families at the state level				#		#				
Coordination of care for children and families across services and systems occurs regularly at a state interagency level				#		#				
At the state level, families are influential partners working with agencies to decide youth/family policies										
At the state level, youth are influential partners working with agencies to decide youth/family policies										
Families have strong statewide advocacy organizations										
Youth have strong statewide advocacy organizations		#								
Individuals working together to improve children and family services, represent the diversity of the state										
Agencies work together to effectively address racial/ethnic disparities in service delivery (state level)										
Agencies work together to ensure services for children and families are culturally and linguistically appropriate (state level)										
The State has an effective approach to coordinate funding across child serving systems				#		#		^		
The State maximizes the use of federal funds (e.g., Medicaid, federal grants, other federal entitlements) for children and family services				#						
There is a clear and feasible plan for sustaining fiscal support for children and family services in Nebraska				#		#				

State System of Care Components	Service Delivery System									
	CW	DD	EC	ED	HC	MH	SA	VR	JJ	O
Nebraska has an effective approach to ensure workers are trained in the system of care approach						#				
Workers are trained to effectively provide high-fidelity wraparound (state level)						#				
Workers are trained to effectively provide evidence-based treatments (state level)										
A state-wide social marketing/strategic communication plan to inform key stakeholders about the system of care										^
Key state leaders are partners in state efforts to communicate about the system of care				#						^
Data and family stories are used to communicate about the system of care at the state level				#						
Agencies are working in partnership to support high-fidelity wraparound (family centered practice) at the state level				#						^
Fiscal policies are in place at the state level to support and sustain high-fidelity wraparound (family centered practice)				#		#				
The state tracks outcomes and adherence to high-fidelity wraparound (family centered practice)				#						
There is a strong state effort to redeploy funds from higher cost to lower cost services										
There is a strong state effort to focus on prevention services				#		#				
There is a strong state effort to focus on early intervention services						#				

Green^ indicates system rated component higher than those not in that system; Blue# indicates system rated component lower than those not in that system.

CW = Child Welfare	MH=Mental Health
DD=Developmental Disability	SA=Substance Abuse
EC=Early Childhood	VR=Vocational Rehabilitation
ED=Education	JJ=Juvenile Justice
HC=Healthcare	O=Other (e.g., faith-based organization, childcare, legislative aid, services for visually impaired, mentoring programs, violence prevention)

APPENDIX 7: SUMMARY OF QUALITATIVE ANALYSIS

Policy/Administration/Regulation

Model collaboration at the state level

"It has to start from the top. If the agencies at the state level aren't talking to each other, it is impossible for collaboration to occur regionally or locally."

- Medicaid and Child Welfare need to participate fully
- Schools need to participate in policy changes
- Implement systems of care philosophy in state services
    - Use high fidelity wraparound (family centered practice) in all state systems
    - Monitor fidelity to EBPs in state systems (e.g., caseload)
- Provide framework, data and resources for local implementation of systems of care
    - Create policies that allow for creativity by local collaborations to meet local needs
    - Identify mechanisms to encourage and fund community collaboration development

      "There needs to be agreement about what the outcomes should be, but then allow communities to be flexible and creative to achieve solutions that work within their communities."

Align and streamline administrative procedures so they are family friendly

- Create one shared intake process that does not need to be repeated across systems
    - Create mechanisms for information among systems that respect confidentiality
    - Consider one application covering all state funded programs (e.g., Medicaid, Food Stamps)
- Balance efficiency with being family centered

"Families prefer to talk with a live person when contacting DHHS"

- Review procedures to speed eligibility determination in multiple systems at once
    - Discontinue requirement of failure at lower levels of care before higher intensity services can be accessed

Review and align service definitions, reimbursement rates and funding roadmaps

"Medicaid has made it difficult for low income families to find high quality services. Many providers do not accept Medicaid families due to low reimbursement rates."

- Require insurance to cover child mental health /developmental services
- Review Medicaid reimbursement rates and covered services
    - Ensure Medicaid covers and reimburses EBPs
    - Create a policy that reimburses providers for participation in team meetings
- Review eligibility, stop dates and rules for state funded or Medicaid services for children and youth across systems

  - Identify gaps and contradictions among system procedures and rules with families at the table

"Insurance and program eligibility shouldn't dictate if my kid gets help; if they need help why can't there be one organization that provides it, period."

- Create shared mechanisms for flexible funding of support resources across systems
- Prioritize service development of prevention, early intervention and crisis services for children and youth
  - Identify and advocate for policies that support EBPs for Autism spectrum

Develop workforce capabilities to use EBPs

- Identify preferred evidence based practices
  - Coordinate with funders to ensure evidence based practices covered
  - Create incentives for provider adoption of evidence based practices
- Investigate why there is such a high turnover of caseworkers and tprovide appropriate support to retain good workers
- Identify and implement common education/training for everyone working in child serving systems
  - Instill a culture of customer service and family centered practice in state funded systems
- Create education system standards for safety, working with children who have complex behaviors and team meetings (family centered)

Create system measures that are transparent, accessible and used for system adjustment

- Incorporate fidelity monitoring in system quality assurance measures
- Collect and aggregate data around performance measures across systems
  - Create shared data points across systems
- Identify common system measures for use across child serving systems (including schools)
- Produce both quantitative and qualitative measures of system development
  - Monitor perceptions as well as numbers
- Monitor and provide feedback to communities on status of DHHS/Probation changes
- Evaluate impact of "zero tolerance" policies in schools on children and their families (e.g., truancy rules; bullying rules)
- Monitor data for trends (disproportionality)

Trauma Informed Care

Create a common understanding of trauma across systems

"Early intervention, and education and training are key, and say trauma is trauma not just bad behavioral and what trauma causes"

- Use a common curriculum to educate professionals in all systems about trauma (child welfare, education, behavioral health, and medical/health)

- Educate families about trauma and what professionals should know about trauma
- Educate the public about trauma impacts across the age span

<u>Systematically implement practices that are trauma informed in all systems</u>
"We've have the training but how do we help each other operationalize that?"

- Identify and promote specific evidence based practices that are trauma informed
    - Promote EBPs for schools; foster parenting; court/justice; medical; child welfare; law enforcement; clinical settings
    - Monitor fidelity of trauma informed practice implementation
- Implement common assessment tools to create a shared understanding of trauma impacts that can be shared across systems
- Review system administrative processes to ensure they are trauma sensitive (e.g., conducting investigations)

<u>Create and implement systemic plans to address and prevent secondary/vicarious trauma of workers</u>

- Assess potential trauma impacts of institutional or system change prior to implementation
- Disseminate best practices for prevention of vicarious trauma across systems

Family and Youth Involvement

"Listen to what the family says. Too much is based on evaluations done by doctors that see the child for maybe 45 minutes."

- Families believe professionals don't communicate with them well while providers and stakeholders repeatedly pointed to communication as their strength.

    In our situation we had county attorneys, OJS, tracker, supervised visits, there were about a dozen people and there was no set communication. That's where my support worker and p2p helped calm me and get people together, but even then it seemed they didn't take their responsibilities seriously.

- Involve parents in team meetings
    - Family view:
        - Recognize that often the family system is under stress
        - Tolerance and understanding is needed to work well with families

            Truly involve the parents in the planning, don't assume they are bad parents. …Stay with the family for a longer period of time… The family should have feedback as to how long they are worked with, instead of being told; "'we think you are doing great so we are going to complete your plan, is that okay?"

        - Schedule meetings at times parents and advocates can attend

        - Professionals see things only through their own lens
        - Intervention is often "blame based"
        - Power differentials in team meetings limit family voice (us vs. them)
    - Provider view:
        - Recognize some parents aren't ready to advocate for child's best interest
        - Parental accountability is important

            Some parents don't want better things for their kids. Some parents don't want to look bad. Parents expect systems to fix kids. Parents need to understand their responsibilities and how to raise their kids.

    - School view:
        - Involve school personnel who work with children most of the day
- Increase opportunities for system level involvement for youth and families
    - Don't rely solely on family organizations to represent all families and all youth

        It appears that one or two families and one youth represent the "family" and "youth" voice at all meetings (I see the same person or two people) which is not a fair or accurate representation. There is not a good mechanism for sharing the consumer/family perspective.

    - Equip family members and youth so they know how to participate
        - Provide education about how to be involved
        - Hold community collaborative meetings when families/youth can attend
    - Project Everlast is a strength – but is limited to foster care youth
    - Magellen My Life is a potential strength – but it is not grassroots
- Youth face extra barriers to involvement
    - Not taken seriously at team or system level meetings
    - Basic needs must be met before system level involvement can be expected
    - Sometimes parents try to protect youth by excluding them from team meetings

        Parents keep kids out because if the meetings aren't strength based there is a reason the youth isn't there.

Cultural and Linguistic Competence

"I'm not even sure we even have a good definition for cultural and linguistic competence"

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<u>Prepare the child serving system workforce to work with diverse cultures</u>

- Attract, develop and retain bilingual provider staff, especially Spanish

"Hiring bilingual bicultural workers is hard because they don't always test or interview well. We need to dig into references to find out who a person really is."

"For us to hire bilingual staff is really a training period for others to hire them away from DHHS."

- Develop professional interpreters (including sign language) with knowledge of systems and cultures

"Interpreters need to be trained in mental health world and should address their secondary trauma."

- Cultural issues impact understanding of mental health for workforce members

"International professionals in the community working in systems need education about American system and mental health."

- Workforce needs education about using interpretation services (in person and via technology)

Cultural is more than race and ethnicity

- Gender; Poverty; LGBT
- Family culture; Religion
- System culture (courts; mental health; substance abuse; child welfare)
- Rural vs. Urban

"When you try to get funding they want you to be culturally competent but funders don't recognize rural/frontier culture"

Incorporate diversity in system planning, implementation and evaluation

"We don't involve people of color in system building; takes a big effort to get a diverse voice and we will build another system that is again not capturing the diverse voice. "

"Use of data to drive decisions about disproportionality is lacking; need to standardize information collected and to invest in data interpretation"

Financing

Overall, More funding is needed for children's behavioral health services

"More funding has to be infused - schools and providers can't absorb any more without additional resources and support"

- Build in a plan to sustain funding over time

"Often, after a couple years the funding goes away and is not sustained. The problem is it takes resources out of other programs while they are trying to meet the demands of the funded program."

Allocate funding to locate behavioral health services in schools

"Look at how you can allocate funding and push services and trained providers and caseworkers into the school setting as a place for services to start. This is where we often identify the mental health needs, where we can monitor student growth, where we can begin to build relationships with families, where we can bring resources to isolated communities."

- School systems should have social workers in more schools

"If funding were available, I think an excellent improvement in child services would be to place a full-time, highly qualified social worker and child counselor in each Title I school and half-time ones in each non-Title I school."

Make flexible funding available for formal and informal supportive services

"Would like to see some sort of flex funding be made available for youth/families before they enter in to costly systems of care"

Adjust policies and regulations to create funding streams supporting EBPs and system of care team participation

- Adjust rules for authorizing services that are EBPs
  "Magellen doesn't approve when it deems it behavioral rather than mental health so it is hard to get payment for service authorized"
- Fund development and sustainment of EBP capacity (e.g., MST; ABI; EMDR)
  "If we don't have a lot of kids in a service the service may not have enough business to sustain it."

  "Bruce Perry talks about treatments kids need to overcome trauma and at the same time Medicaid says they won't pay for it. Seems like one part of the state (bh) says it works and use it and Medicaid won't pay for it (EMDR; art therapy; play therapy)"
- Consider ways to braid funding streams so they follow the child
- Create service coordination rates for providers
  "Fund the necessary case coordination efforts that the teams provide. Set a fair rate for home based MH treatment"
- Fund cross-system youth crisis teams
- Align billing and administrative forms/procedures across systems (child welfare, regions, behavioral health and Medicaid)
  - Use a common definition for medical necessity
  - Create a single overarching group with power to review and align system procedures; referee funding for children with needs that cross systems; and provide oversight for mapping fund usage across child serving systems

Address low reimbursement rates across all systems

- Create incentives for EBP use, team participation and provider investment in system coordination
- Create travel reimbursement rate
  "Lack of funding for providers to take the time to build relationships with families that have high trauma and stigma needs. Lots of work that needs to be done on non-billable time"
- Incentivize family care over foster care

"If a child goes into foster care they would have received somewhere between 700-1000 a month compared to 200 for families."

Workforce Development

Nebraska has a shortage of behavioral health professionals with expertise working with children/youth

- Child psychiatrists
- Therapists and counselors with specific expertise in EBPs for children and youth
    - School social workers are underutilized
    - DHHS should use more qualified social workers
- Substance abuse treatment professionals with expertise working with children and youth
- Providers with expertise working with co-occurring problems
- Autism spectrum specialists
- Recruit, educate and retain foster parents to care for children with complex behavior problems
- Recruit, educate and retain more family/youth peer advocates in all areas of the state
- Recruit and retain a more diverse workforce in all child serving systems

Compensation of providers specializing in work with children is too low

"You can teach the skills of high-fidelity wraparound to anyone, but there are workers that are truly skilled providers that are severely underpaid and overworked. This causes workers to leave the field and leaves families, agencies and youth at a loss."

- Encourage use of evidence based treatments by paying for development of capacity
    - Create financial incentives for service providers to use EBPs
- Adjust rates or create reimbursement for "windshield time" for rural/frontier providers
- Create financial incentives or rates for participation in coordination teams
- Create financial incentives to attend or obtain education about EBPs

Families want the workforce in child serving systems to be informed, understanding and available

- Education for all professionals in child serving systems should include the topics of trauma, social/emotional development, screening for problems, family centered practice and active listening (to enhance understanding)
- Provide regular education about system of care and high fidelity wraparound principles to prepare workforce for team participation
- Promote cross-training among the workforce
    - Child welfare workers should understand treatments; law enforcement should understand wraparound etc.

- Promote coordination and referral by fostering a workforce that embraces the "no wrong door policy"
- Review caseload requirements and keep them low
- Youth and family want providers who understand culture
  "We are in desperate need of professionals such as psychiatrists, therapists, social workers, teachers, advocates, doctors, and nurses that are knowledgeable in the diversity of each culture and their beliefs along with the family dynamics."
- Families want child serving workforce to be available weekends and evenings

Develop workforce skills to ensure specialty treatment and intervention is available when needed

- Encourage and fund competency based training to create expertise in:
  - Gender (working with girls, LGBT issues, gender identity)
  - Sex trafficking and sexual assault
  - Teen mothers
  - Gang prevention/education
  - In-home therapy
  - School based therapy
  - EBPs (High Fidelity Wraparound, Multisystemic therapy ; Applied Behavioral Intervention)
  - Treatment of Reactive Attachment Disorder
  - Behavioral intervention (not mental health intervention)
  - Crisis intervention

Marketing and Strategic Communications

Conduct a public awareness campaign emphasizing success

"Lack of awareness – mental health doesn't share success and things that work so people know that things work"

- Use a Public Health approach (e.g., health literacy)
- Make awareness material clear, direct and understandable
  - Use positive language to educate public about mental illness
  - Use stories to illustrate effects of getting help
    - Equip families and youth with skills to help them tell their stories
- Educate general public about what a system of care is
  - Enlist champions and culture brokers to carry the message

Educate families and helpers to keep children and youth safe

- Families want concise information about suicide, safety and managing crisis behaviors
  - Include information to help families ask questions of professionals to help them keep their children and youth safe

- Helpers want information to help with them assess behaviors and make appropriate referrals
    - Families want helpers to know how to manage serious behaviors
    - Families want helpers to know how to keep children and youth safe

Social marketing must address stigma

- Families and youth fear being labeled
  "Make services more known and break the stigma connected to mental illness so that you don't feel ashamed to get help."
- General community has preconceived negative ideas about who mental illness affects
    - Messages should emphasize that mental illness can be in any family
- Professionals have negative preconceived ideas about the families involved with child welfare and behavioral health systems
  "Most agencies look down their noses at our clients."
    - Misunderstanding of services and who they are for limits referrals and utilization rates

  "We have a lot of stigma around what it takes to access services for families, and in turn we have underutilized services, but we have family programs for anyone whether youth have mental health diagnosis or not, and we had 3 referrals last year."
- Educate legislators about mental health and stigma

Market where and how to get help

- Families want a single person, place or location to get information about behavioral health conditions, resources/treatment options, eligibility for resources, and how to access them
- Professionals want information about services to help educate families about local options
- Information about services should be simple and easy to understand
- Information about behavioral health should use positive language (hope)

Marketing should contain a specific plan to reach at-risk families

- Education/engagement plans must reach culturally and linguistically diverse families
- Multiple modes of marketing are needed to reach families

"We are all grouped together because we have children with mental health issues the best way to reach us is a variety of ways so some families that you may not reach can be reached . We are individuals and need to be related to on a case by case basis."

- Personalize outreach locally when possible (Email; small group meetings with food and daycare)

- Utilize natural gathering places for families and youth to get messages (schools; sports; activity centers; physician offices)
- Equip helpers with information for at-risk families (Cultural centers; therapists; teachers; lawyers; youth leaders; faith leaders; AA groups)

Wraparound

- Support development of local interagency teams
- Allow local teams flexibility to identify services and supports needed in their area

  "By NE assuming on a state or policy level that they know what each community needs, a gross generalization is being made that contradicts the implementation of high fidelity wraparound. Provide the framework, tools, data on a state level. Distribute that to communities with specific expectations and timelines for implementation. For communities that do not have a formalized interagency team- pull individuals from communities that do to help them first build their collaborations. Do not expect every community or region to progress at the same rate"

- Fund high fidelity wraparound as a direct service
- Adjust the service definition for wraparound to extend beyond 90 days

  "When working with a family to improve all aspects of life, the wrap around partner should NOT have a stop date for care. The families ask for support when their lives are in shambles. To lose the support, only adds more trauma to an already volatile situation"

- Consistently implement the same training for family centered practice across all child serving systems
  - Include facilitation training for wraparound teams
- Identify service coordination options as an alternative to high fidelity wraparound

  "There are families who will not respond to high-fidelity wraparound - for a variety of reasons but which often include substance abuse issues. We need to be able to intervene quickly to provide care, support, and stability for kids who are in situations here their family is not healthy and not moving toward being healthy."

- Make high fidelity wraparound affordable for all income levels by adjusting eligibility requirements
  - Identify wraparound alternatives for children age 3-9

Prevention and Early Intervention

<u>Fund and promote more preventative services</u>

"This will require a paradigm shift in mindset and focus away from reacting and towards proactive policies beginning with an emphasis on early childhood and family support through community based strengthening efforts."

- Locate prevention programs in schools and medical settings
- Replicate Nebraska Children and Families Foundation local community initiatives
- Fund prevention programs focused on early childhood
- Fund prevention programs focused on risky behaviors for youth (suicide, substance use, safety, bullying)
- Educate professionals to promote social/emotional development in children
- Promote a culture that values education to prepare adults to be parents
- Include early childhood providers in community collaborative teams (e.g., Head Start)
- Prepare mentors to work with children with complex problems
    - Create support networks for working with high risk children and youth

<u>Build and fund an array of early intervention services</u>

- Promote early childhood screening and behavioral health assessment
    - Address barriers to sharing assessment data among child serving systems
    - Support and encourage colocation of mental health and primary care
- Screen children and youth regularly for developing behavioral health issues
- Ensure wraparound services are available to families with young children
- Promote EBPs for use in early childhood in a variety of settings (school, daycare, home)
    - Ensure EBPs for early childhood are reimbursable services (Medicaid; Magellen)
    - Address limits on eligibility and number of covered services/visits for young children
    - Subsidize development of EBP capacity for providers and schools